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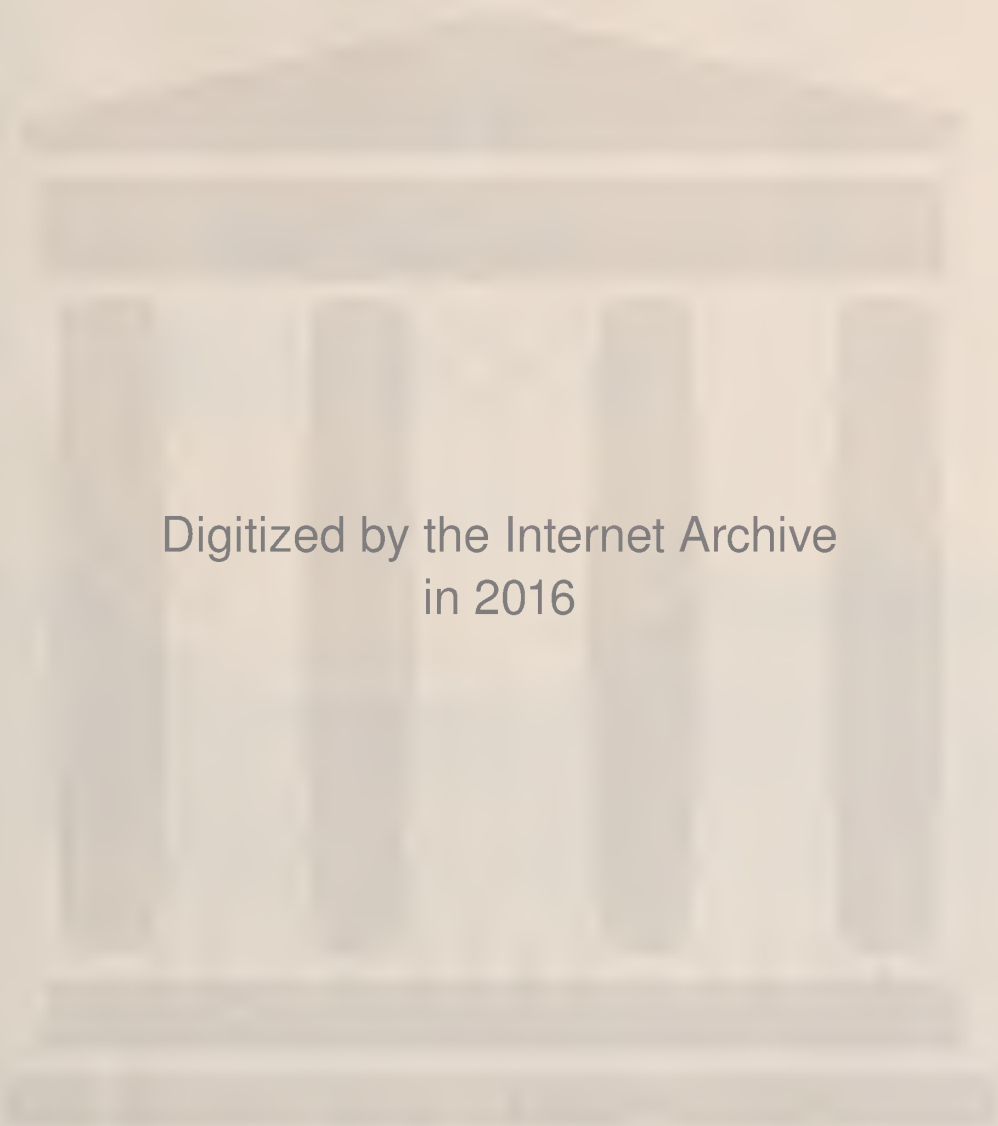

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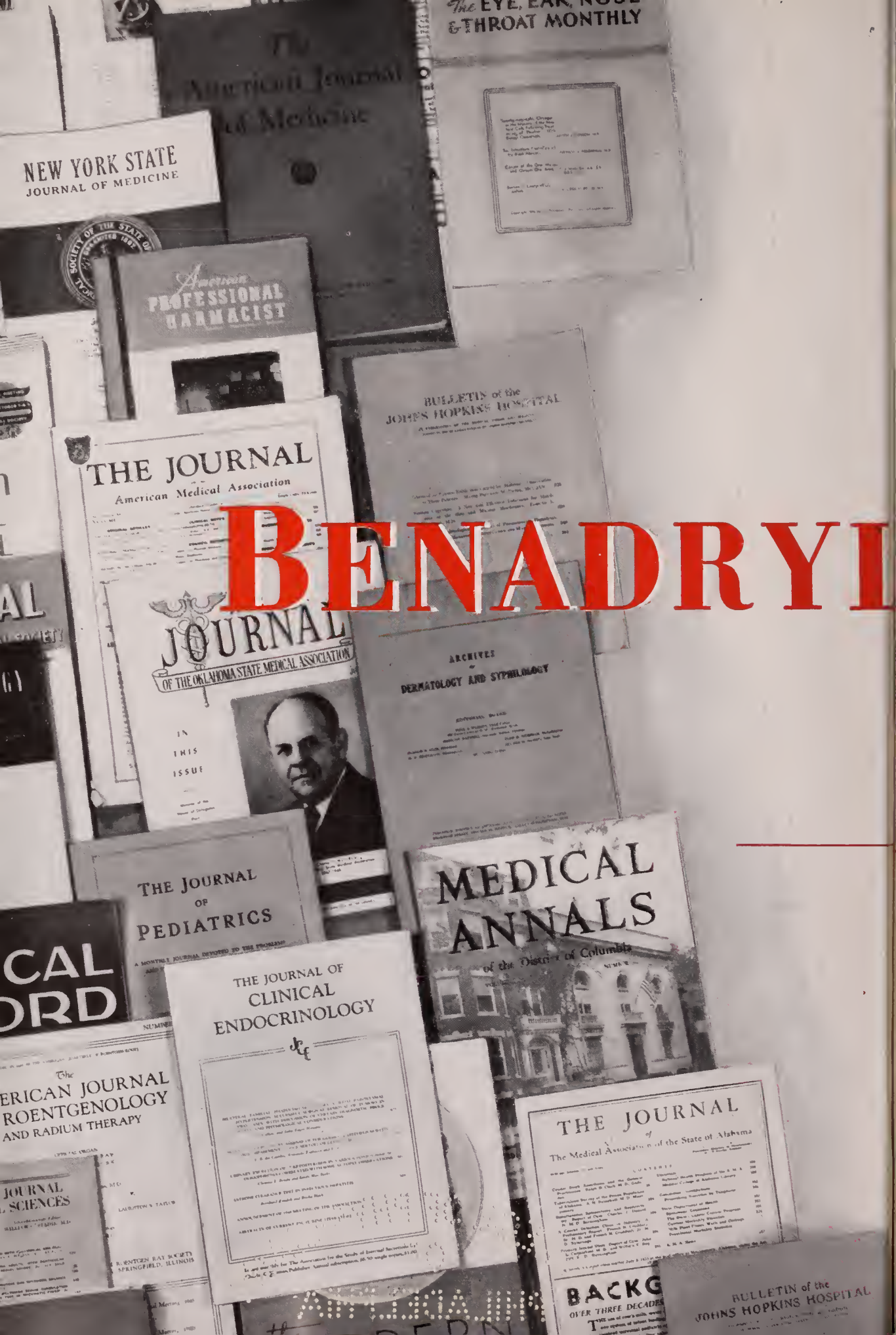
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TABLE OF CONTENTS

	Page
President's Page	38
An Introduction to the Law	35
Medical Economics and Organization Section	39
Abortion, Criminal	64
Agreement on Panel Practice	76
American Medical Association	
Medical Ethics, Principles of	149
Officers of	154
Autopsy	62, 82
Basic Science Law	
Enforcement	57
General	46
Board of Health, State, Services, Laws, and Rulings	113
Child, Care of Illegitimate	90
Chiropody	51
Chiropractic	52
Collection of Accounts, Outline of Laws Governing	92
Compensation Act, Workmen's	69
Constitution and By-Laws	130
Coroners	82
Council Award, Recipients of	148
Dangerous Drugs, Sale of Regulated	87
Dead Lines	158
Deaths, Registration of	45
Diagnostic Services, Community	119
Diseases, Reporting of	113
Doctor, Use of Title	56
Estate Tax	39
Externes, Legal Status	67
Fee Splitting	60
G. I. Bill of Rights	96
Gift Tax	39
Health, State Services, Laws, and Rulings	113
Hospital Records, Access to	108
Illegitimacy	90
Inheritance Tax	39
Inquests	82
Internes, Legal Status	67
Jury Duty, Physicians Exemption from	89
Leases, Office	43
Licensure to Treat the Sick, Limitations of	56
Life Insurance, National Service	104
Loans and Grants for Veteran Doctors	106
Malpractice	61
Marijuana	85
Marriage Laws	88
Massage and Hydrotherapy	52, 57
Medical Ethics, Principles of	149
Medical Practice Act, Enforcement	46
Midwifery	51, 57
Miscarriage, Criminal	64
Naprapaths	48
Narcotics	
Administering, Dispensing, Prescribing	84
Federal Law	84
Marijuana	85
Penalties	85
Purchase of	86
Registration, Narcotics and Marijuana	86
Wisconsin Law	84
Naturopaths	48
Optometrists	53, 57
Osteopaths	50, 56
Panel Practice, Agreement on	76
Postmortem	62, 82
Premarital Examinations	88
Reciprocity Licensure Rules	68
Registration of Deaths	45
Residents, Legal Status	67
Respirators, Locations of	164
Sick, Treating in Wisconsin	
Basic Science Law	46
Chiropody	51
Chiropractic	52
Educational and Other Requirements	54
Licensure	
General Requirements	47
Limitations	56
Massage and Hydrotherapy	52
Medicine and Surgery	48
Midwifery	51
Optometry	53
Osteopathy and Surgery	50
State Health Services, Laws, and Rulings	113
State Boards and Commissions, Officers of	122
State Medical Society of Wisconsin	
Charter Law of Medical Societies in Wisconsin	129
Constitution and By-Laws	130
Councilor Districts, Maps of	128
Fifty Year Club, Members of	137
House of Delegates, 1947	137
Membership, December 1947	139
Officers and Committees	124
Past Presidents	162
Sterilization	65
Tax	
Estate	39
Gift	39
Inheritance	39
Marijuana	86
Narcotics	86
Testimony	
Medical Witnesses and Expert	77
Privileged Status of Physicians in Legal Proceedings	80
Treating the Sick in Wisconsin	46
Tuberculous, Laws and Rules for the	120
Veterans, Record of Service Rendered to	160
Vital Statistics	117
Wisconsin General Hospital Law	111
Wisconsin Veterans Medical Service Agency	97
Workmen's Compensation Act	69
The Journal Bookshelf	164
Index to Advertisers	172
Physicians' Exchange	170

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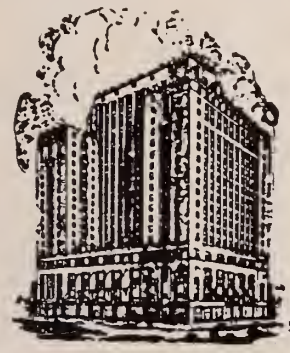

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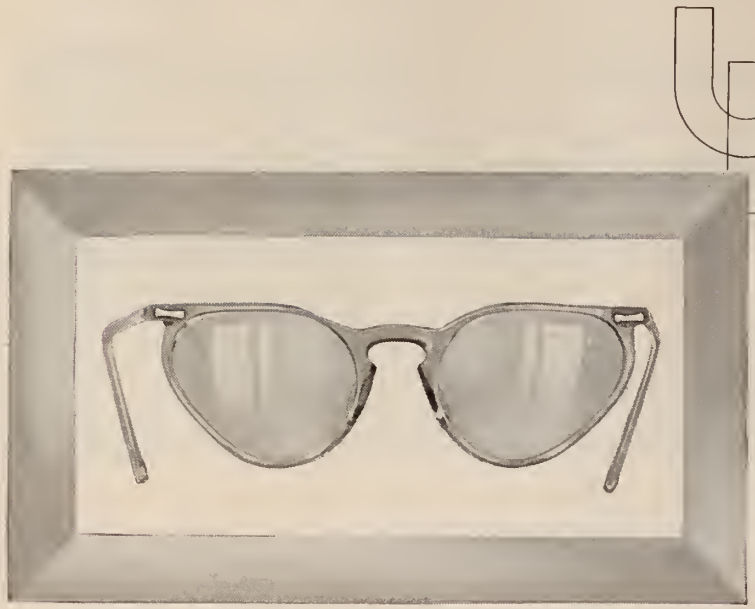

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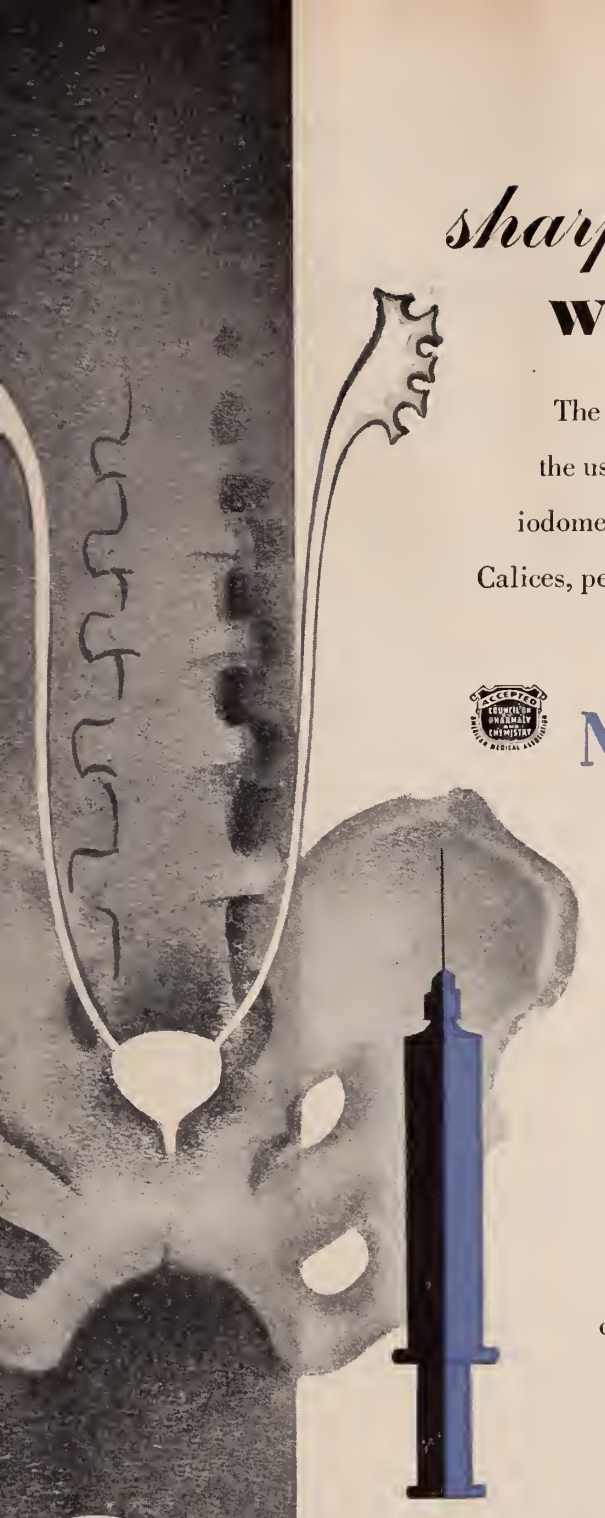

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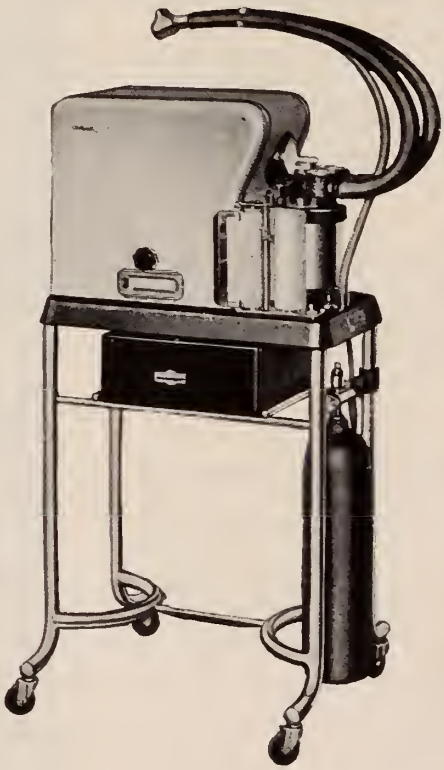

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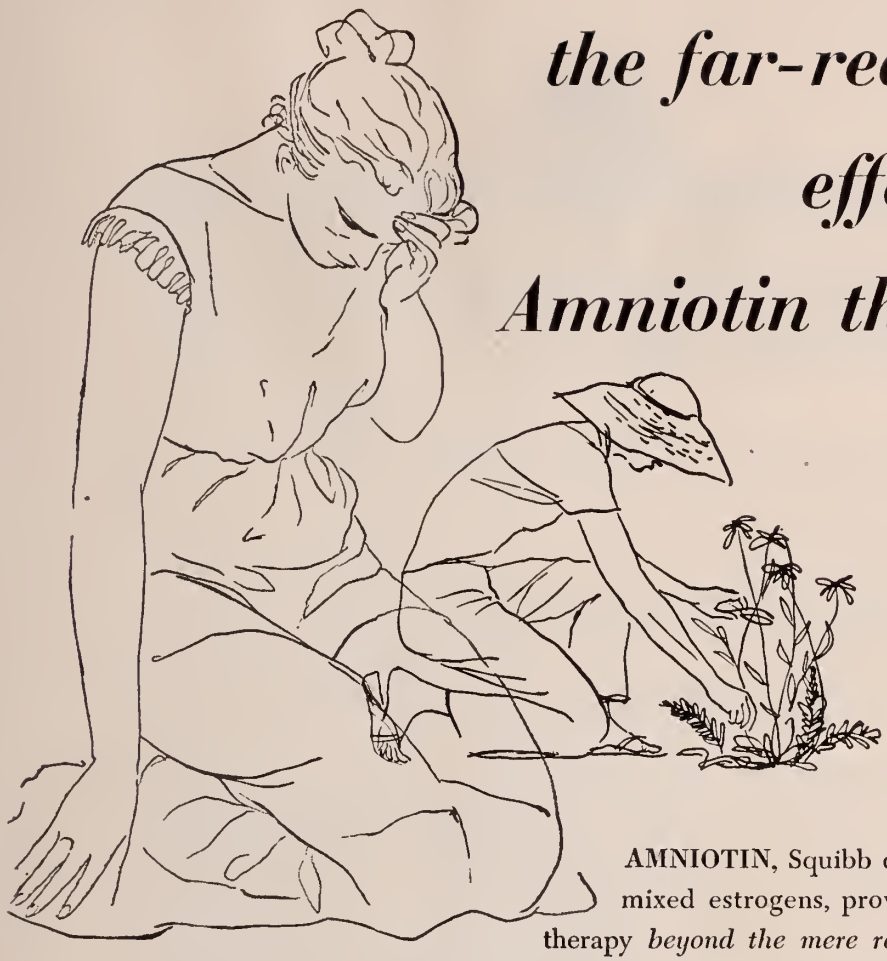

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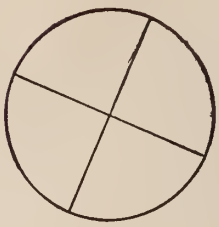

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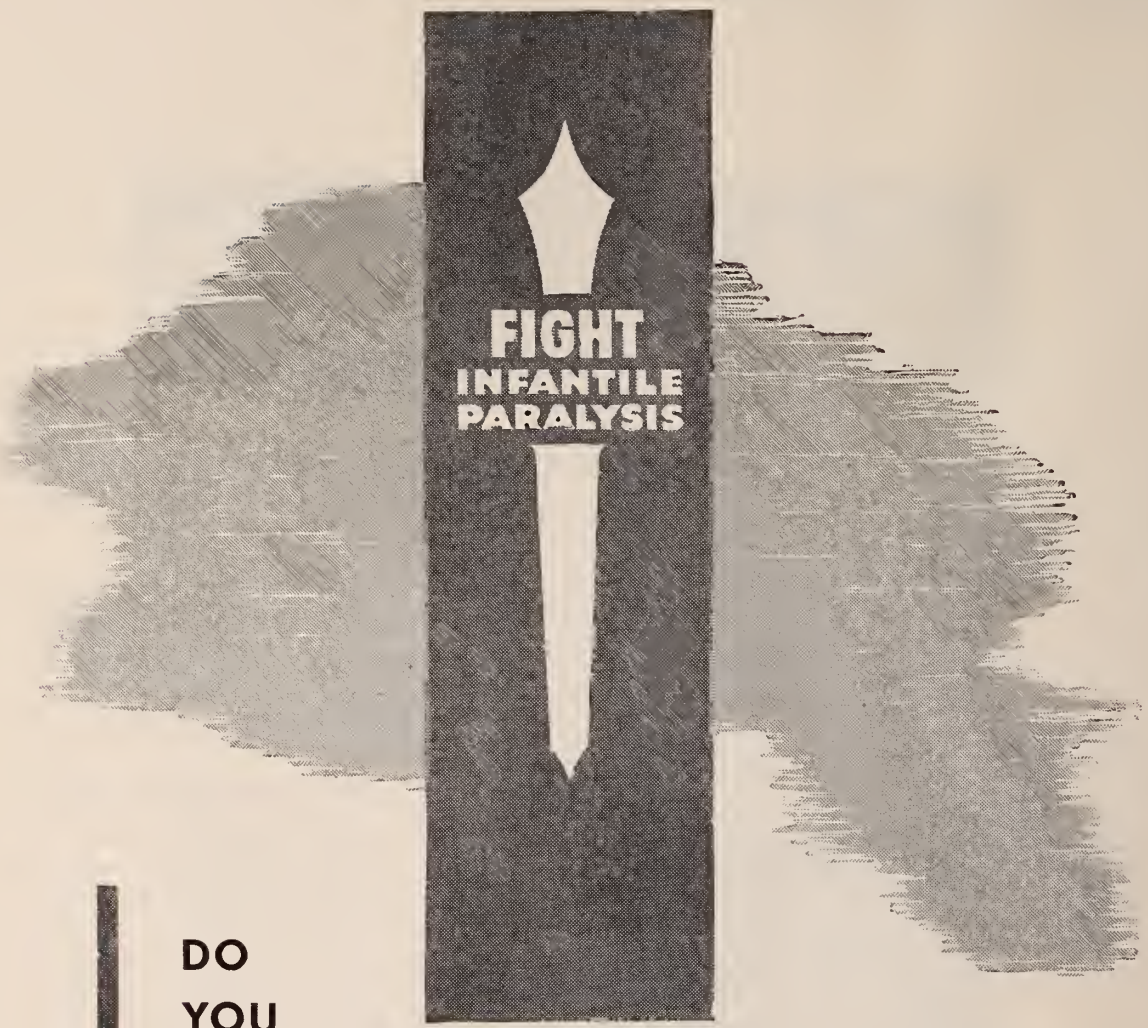

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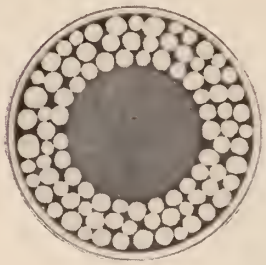

LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

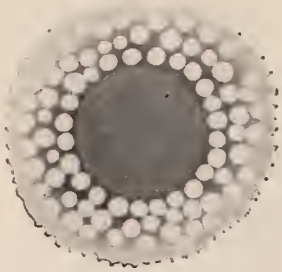

Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

Fig. 3 — Complete disintegration.

We direct your attention to AMINOPHYLLINE ENTERIC COATED B-M — valuable when the patient experiences gastric irritation from aminophylline.

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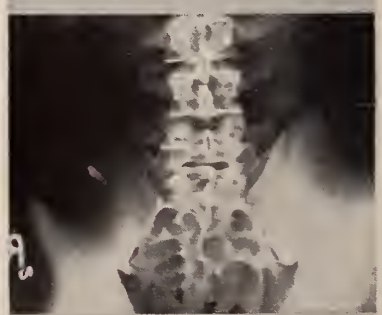
Radiograph taken five minutes after intake of 6 tablets Enteric Coated B-M . . . all tablets are in stomach.

Four hours later . . . all tablets now in intestines.



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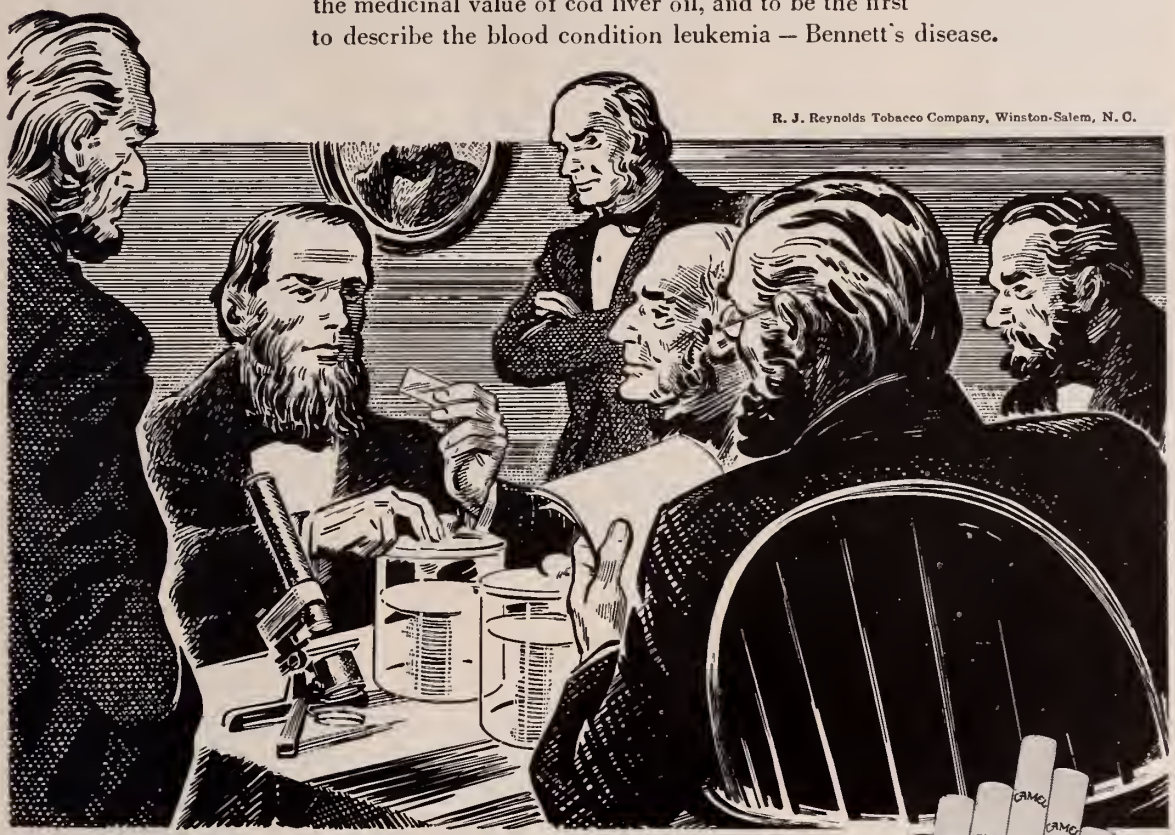

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1. Dunn, H. L.: Am. J. Pub. Health 36:1412 (Dec.) 1946.

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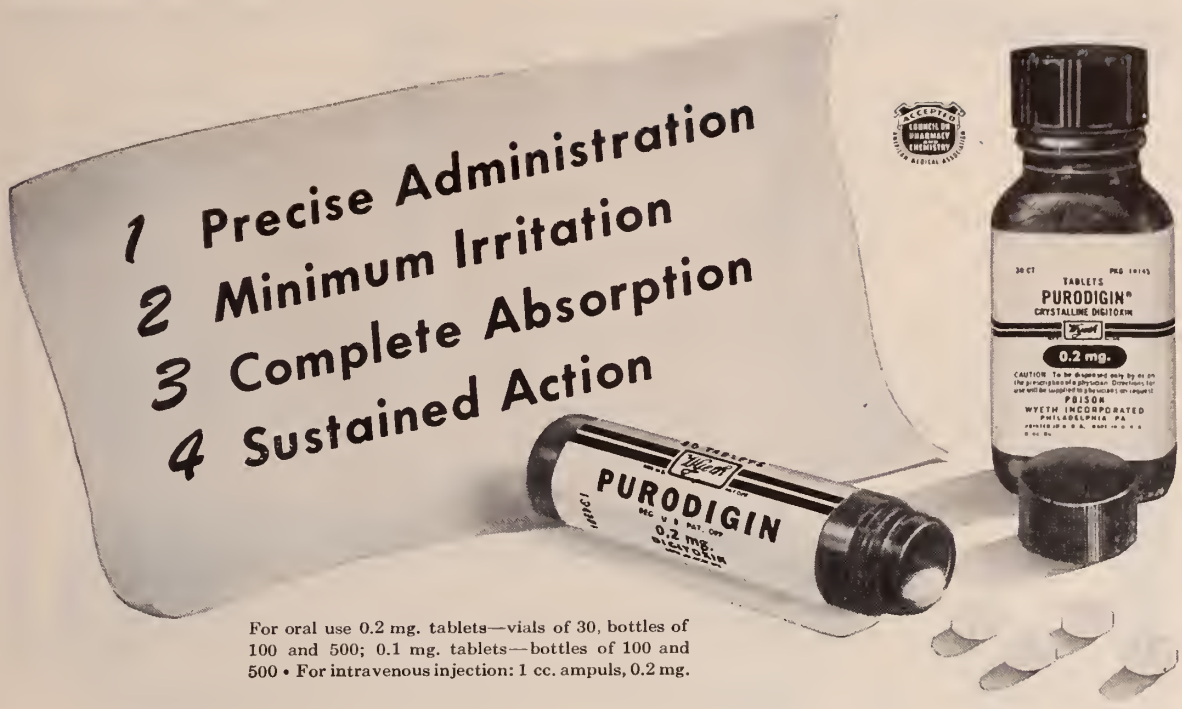

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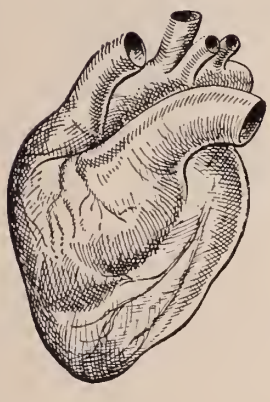

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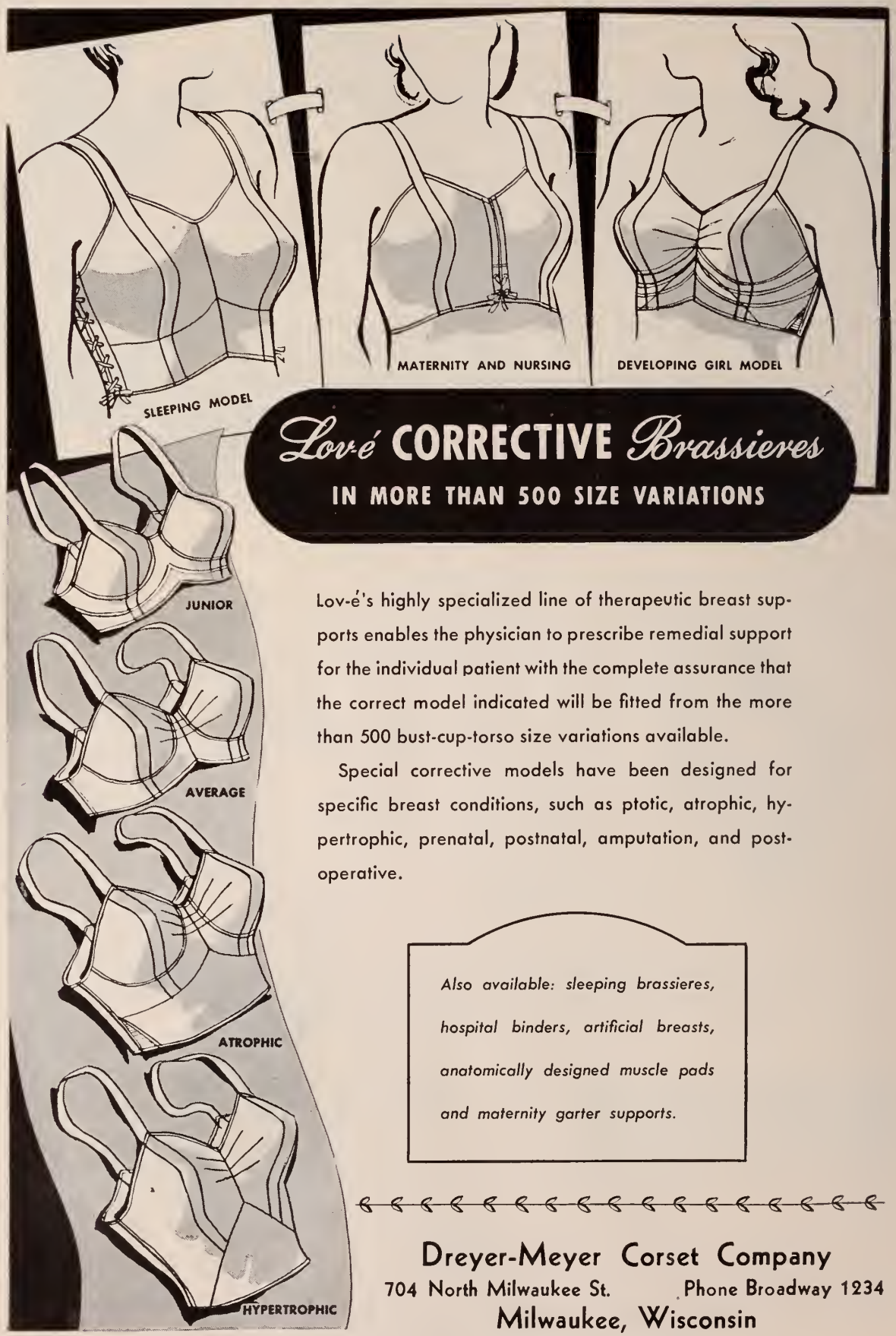

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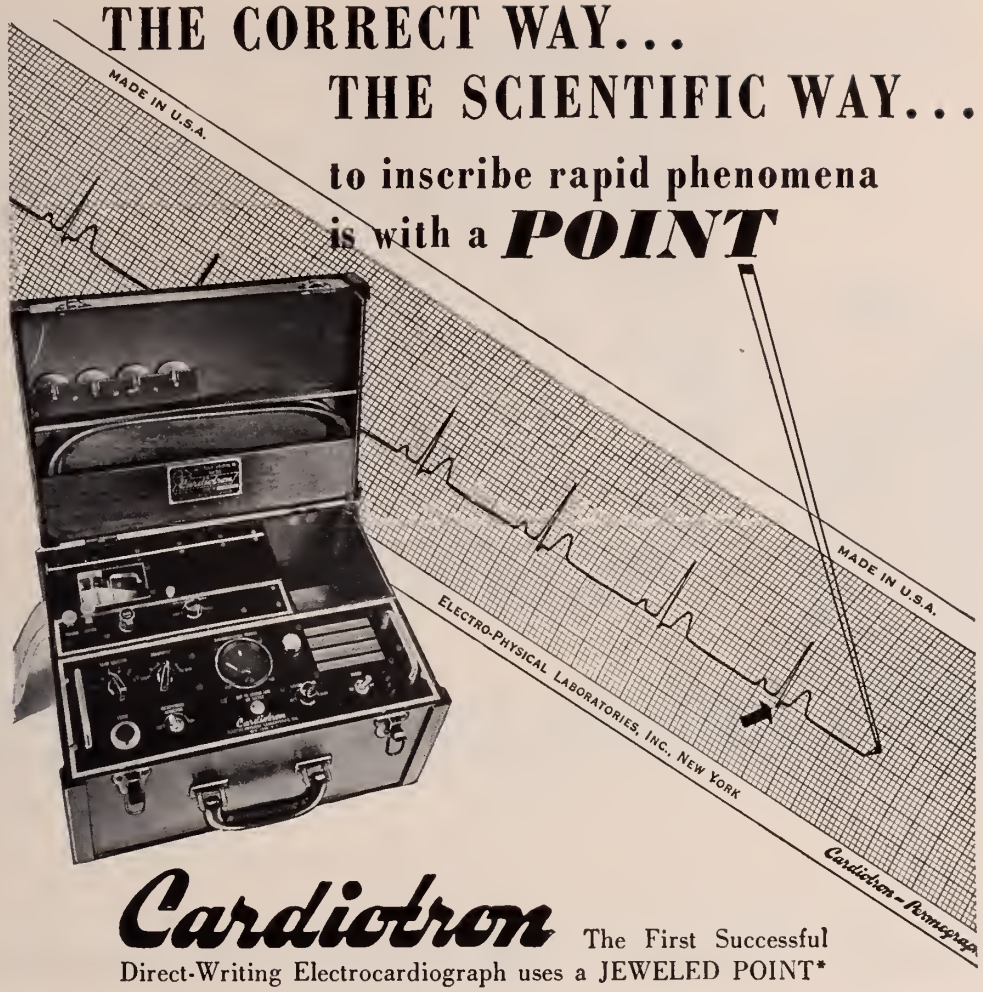

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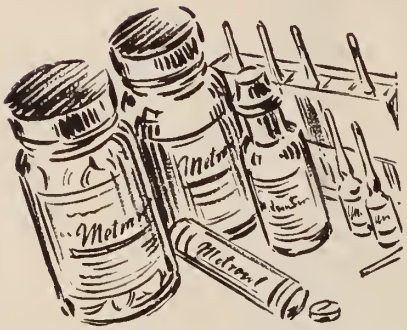

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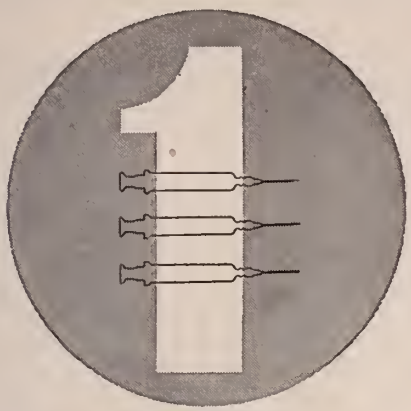

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Volume 47 JANUARY, 1948 Number 1

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An Introduction to the Law*

FOR many years the several medical schools of this and other countries have presented a course under the title of "Legal Medicine" or "Forensic Medicine." The courses have and still do vary widely in scope and manner of presentation and from most of them the student fails to obtain a clear picture of the law. The following simple review is presented in an attempt to cure or alleviate this defect in the curriculum and is based upon the premise that students who graduate possessed of an elementary appreciation of the law and the fundamental principles which underlie it will be better physicians than those who merely visualize the law as something they had better shun.

What Is "Law"?

Everyone should realize that the "law" is an organized body of knowledge just as "medicine" is. It is the sum total of the rules of conduct which are concerned with the rights and duties of people and administered through the mechanism of a system of courts. It is the set of rules which applies and governs the acts of people in their several relationships with one another and is enforced by the state or federal government. The law, like medicine, was not invented or made up by any one person but it is the result of centuries of development from the welter of maxims, customs, and usages which prevailed among our very early forebearers and more recent ancestors. Just as medicine has always been concerned primarily with but one thing, —the prevention and cure of disease—so has the law always been concerned with but one phase of our social existence—the prevention and settlement of disputes. It has always been the mechanism which people used to handle their potential and actual disputes in an orderly manner according to the legal rules and principles which were in effect at the time.

In the early centuries when the witches and others in the healing profession were busy boiling up scorpions and vipers and reciting their incantations, the law was similarly primitive. It consisted entirely of tribal rules and customs which were known to all. In those days it so happened that the smallest unit in the tribal (social) structure was the family, not the individual. If some individual was injured by a member of another family, the members of his own family were the ones who had to decide what retaliative measures were to be carried out. In the event the injury proved fatal some member of the deceased's family was given the "right" to exterminate a member of the assailant's family at any time, place, or manner he chose. This plan of conduct seemed to work fairly well in those days except that these family fights often went far beyond the stage of being strictly private quarrels and developed into intratribal wars which seriously impaired the strength of the tribe as a whole. Because these feuds rendered the tribe more susceptible to defeat by other tribes, the tribal leaders began to devise ways and means of stopping them, and herein is found the first evidence that the tribes were beginning to feel the need of a central governing body or chief.

Early Settlement of Disputes

One of the first of the schemes to stop them, and one which is still utilized today in a somewhat modified form, was to permit the wrongdoer to buy off the family's "right" of revenge by giving them a certain amount of money termed "blood money." Another device was the rule which made it mandatory for the family to consult with the tribal head before undertaking any retaliative measures. At each such conference the tribal king would specify that a certain number of days must elapse before revenge could be sought. These were called truce days; today they constitute a cooling-off period. This idea of truce days was a good one and later was extended in the form of peace days. The tribal king would decree that everybody in the land should keep the peace on certain days. And furthermore no one could ever do any violent act in the presence of the king or in his house. The number of truce days and peace days gradually increased, and the amount of territory considered to be in the presence of the king gradually came to mean the entire nation. The end result of this development is that the state still prosecutes all crimes and criminal wrongs.

During the many years it took for this change to evolve, the tribal or local disputes were settled according to law in the local assemblies of the people. These meetings were conducted according to rules which were necessarily handed down by word of mouth from generation to generation and which were in the form of highly formal, rigidly exact formulae. Everyone in the assembly knew the law, and every word and phrase had to be correct. In fact, everything about the ritual, which was the

* Introductory lecture in "Forensic Medicine" by R. L. McIntosh, M. D., Madison.

forerunner of a trial, had to be done in one certain way, and there could be no deviation. These arbitrary, quasi-religious affairs were somewhat less scientific than our present day ones perhaps, but no matter how fantastic they appear to have been they were sufficient for their day. And, furthermore, the custom of conducting trials according to iron-clad rules and in a predictable manner has continued to be a characteristic of our law.

Establishment of English Common Law

By the time the feudal system was introduced and blended into the old customs of the Saxons, the various assemblies had become dominated by some baron or by some chartered borough or some priest or the central government itself, and the business of dispensing legal justice was pretty well split up between them. The central government's bid for control was grealty aided by the dynamic Henry II, who established a system of royal courts which traveled and operated in the several parts of the country. These courts assumed jurisdiction over cases which the local community courts were unable to settle, and the royal judges determined what the law should be according to the customs of the community. Naturally these courts became more and more firmly entrenched as higher courts and the decisions which they handed down were followed by other courts in all parts of the country. This idea of having the courts look to past decisions for the legal principles to be applied in any new situation was not a new or revolutionary one, because it had been used in the local courts for years. However, when it was adopted by the newer and higher courts it was of great value in helping to mold all the rules of law into one uniform system, a system that was common to all, the English common law. Furthermore it has continued to exert a stabilizing influence on our legal system, and, while it has been carried to absurd lengths by some courts, the principle is a sound one. Those medical persons who scoff at the idea of giving any authoritative force to judicial precedents not only are poorly informed but are usually the same ones who have such a high regard for the folk-lore, lengendary data, and obsolete, irrelevant material which clutters up most medical literature. This "bosh" is there because of medical precedent and not because any analogy exists between it and the legal principle under discussion.

About the time when the royal courts were becoming established as part and parcel of the legal system the idea of a jury developed. At first the jurors were little more than mere witnesses, and it took many years before they were made lay-judges who could give verdicts.

Protection of Legal Rights

Probably the most amazing of all the developments in our law is that our legal rights were not even conceived until the legal rules and principles had reached a fair stage of solidarity. While we all know that it is the avowed purpose of the law to administer legal justice by protecting legal rights and enforcing legal duties, it is very obvious that no such a vague, abstract thing as a legal right or duty existed during the early Anglo-Saxon period. The rules of the day existed for but one reason, to preserve the peace. The only right that existed was the right of brute force, but as tribal leaders gradually curbed the blood feuds and extended peace days, the idea of having other rights began to develop. When some early day radical got to the point of doing some thinking in regard to other possible rights, it seemed only logical to him to make out a list of those which were desirable and then develop some rules in regard to them. However, by that time the rules and customs mentioned above were already well established and there was no alternative but to formulate some legal rights in the light of those rules and customs. Naturally the character of those rights has varied from time to time during the centuries which have passed since their inception, but their basic, fundamental attributes were developed in large measure during the same period in which the English common law developed.

Inasmuch as many Americans, real and synthetic, like to talk about our rights at all times and are quick to seek refuge in them at other times, it may be pointed out that our rights and duties are of several legal varieties. We present day Americans have always had the benefit of the right of personal security, the right of personal liberty, and the right to own property. We have had those rights for so many years that we have come to regard them as our absolute rights, rights which are natural and inalienable and are so fundamental that they belong to all. We have come to believe that they are as much a part of us as our arms and legs, and we are quite shocked if not insulted when reminded that these are not rights which automatically attach themselves to every person in this country. Moreover, they are rights which were obtained the hard way and subject to loss in that same manner.

The right of personal security means that in legal theory everyone has a right to have, keep, and enjoy his physical integrity and to keep his health, limbs, body, and reputation intact. The right of personal liberty means that in legal theory everyone has a right to go where he wants to whenever he wants to, to engage in whatever trade or profession he chooses, to employ the physician of his choice, and to attend any church he likes. The right to own property means that in legal theory everyone has a right to own, use, enjoy, and dispose of real property or personal property.

In addition to these three "absolute" rights there are numerous kinds of relative rights we may presently have or may acquire in the future. As a rule, these rights arise in respect to certain relationships such as husband and wife, parent and child, guardian and ward, master and servant, physician and patient, nurse and patient, etc. These relative

rights, together with our absolute rights, constitute our private rights. For each of them there exists a corresponding absolute or relative duty not to violate the rights of other persons; it is a duty which you must do or must not do under certain circumstances.

Legal Privileges

In addition to the legal rights and duties mentioned, some persons have legal privileges conferred upon them by law. That is, they are given a license to do certain acts with immunity from liability. Many businesses operate under a license, and all physicians in practice do the same. Privileges may also be given by an individual to one or more individuals for certain purposes, for example by a boxer to his opponent in the ring.

It is essential that we bear in mind that all of our rights, duties, and privileges are concerned only with acts, not with thoughts. Acts are said to be exertions of the human will that are manifested in the external world, and those which violate some person's rights may have legal consequences. Acts may be acts of commission or of omission, and the legal consequences may be civil or criminal action. Acts are the only things in which the law is interested; it is not at all concerned with a person's thoughts or feelings except as they may give legal character to his acts. As has been pointed out, the law is not based on theory, logic, truth, ethics, or anything else except experience. All that the law is or ever tried to be is the set of rules of conduct which is prescribed by some competent political authority and has as its sole objective the ability to enable people to live together with a minimum of trouble. Even since the days when tribal law was administered according to exact, spoken formulae by the tribal officials, the law has been administered according to a definite set of legal rules by legal officials who are elected or appointed to their positions. The portion of the law which is concerned with the procedure to be followed in legal actions is known as the adjective law in contradistinction to the substantive law, the law which is concerned with our rights and duties. The adjective law is the legal framework made up of the rules which must be followed by our own courts, and yet as our legal officers follow them they may be criticized by the public for either following them too closely or for not following them closely enough. Defeated litigants commonly scream and yell about a miscarriage of justice which was induced by the judge's refusal to go way beyond the full limit of his power prescribed by law in order to arrive at a decision favorable to them. The other person in the same legal action will be less loud in his approval of the judge's ruling but will be convinced justice was done. The law has never been complete and up to date and probably never will be, but in all legal actions a decision is reached according to its present status.

Component Parts of the Law

Just as medicine is divided into various phases or parts such as anatomy, physiology, and pathology, the law is similarly subdivided into component parts. The legal acts which are delictual wrongs and offenses against the person of another are included in the law of torts, while other civil wrongs are violations of the law of contracts. The offenses or wrongs which the state itself prosecutes are crimes. A host of other laws relate to subdivisions of these main groups, and when a person has occasion to "look up the law" for any purpose he has as many kinds of law books to look into as a medical student has medical books.

Briefly, the only authentic repositories of the law, books that are considered to be of primary authority, are our federal and state statutes and the reports of judicial decisions. The former contain many elements of the common law of England which pertained to governmental affairs, while the latter contain many of the characteristics which were general and local customs in the unwritten common law. Some of the cases which were decided between the years 1292 and 1537 and are recorded in the year books contain the earliest statements of the legal principles that are accepted as primary authority; some of the common law cases and chancery cases reported between the years 1700 and 1785 are also accepted as primary authority. However prior to 1865 there was no systematic recording of decisions rendered by English courts, and while the reports of such decisions are actually books of primary authority in our law this is true only in the sense that they may be cited and perhaps followed in a situation which is not covered by an American decision.

The federal law is found in the Constitution of the United States, in the treaties made with other countries, and in the federal statutes. The laws of the several states are found in their respective constitutions and statutes. Our so-called case law is found in the reports of the United States Supreme Court and the reports of the State Supreme Courts.

Physicians, as members of a profession whose knowledge has been the slow accumulation of facts through the ages, should have an appreciation of the structure of our courts and the foundation of a profession which has the traditions and historical background analogous to the profession of medicine. Just as medical findings of today may be advanced tomorrow, the law of today may be modified and radically changed in light of human development and the inevitable change of human institutions. Instead of regarding this as a weakness of the law, all those concerned with the honored profession of medicine should regard courts and legal opinions as the products of the best in social thinking of the moment. To think otherwise is to reflect an ignorance and lack of understanding which is not associated with the type of mind and character of the modern man of medicine.

THE PRESIDENT'S PAGE . . . . Little Journeys

BEING President is arduous at times, but there are many refreshing, encouraging, and invigorating moments. Some of these moments come during trips around the state; visits to communities where the lives and ambitions of people are expressed in their stores, schools, hospitals, and other evidences of private and public enterprise. And then, like coming upon an oasis in the desert, one encounters individual leadership which portrays the warmth of human kindness in constructive actions of citizenship.

A few weeks ago on one of these little journeys which seem to be a part of the duty of the office, I happened upon one of these cases. Located in the northwest corner of the state, surrounded by a dairy farming community, and pervaded with the atmosphere of the north country, Frederic is a village of one thousand people. I was invited to stop over with our good friend, Ted Arveson, for an interlude between meetings in Superior and St. Paul. We arrived late in the evening in a snow storm which had blanketed the countryside. With the lights from the houses imparting a scintillation to the snowflakes, the village created an attractive and peaceful scene.

Very early the next morning my sleep was interrupted by noises of great activity and industry. As I lay trying to determine what sort of industry could be operating at that time of night, the noise suddenly subsided. But this interval of quiet was not to last long. Just as sleep was about to return, the noise recurred. And so it went, off and on, until it was time to be up.

After breakfast, as we stepped out of the house on our way to the hospital, the night noise was explained. Snow was everywhere except on the wide street in front of the house, and looking down the street we saw the huge snow remover and trucks clearing away the snow at the other end of town. By late afternoon the main street and some of the side streets were free of snow, and traffic progressed as if there had been no storm.

I was impressed with the neat appearance of the village and the industry of the people which was everywhere apparent. The stores were well built, and the show windows were filled with well arranged merchandise. Hardware stores, farmers' stores, and ladies and men's wearing apparel stores, beauty shops, and barber shops gave signs of industry, pride, and success. On one side street there was a beautifully designed post-office to which the doctor and his wife had contributed many attractive features.

Standing on spacious grounds adjoining the residence of our friend is St. Luke's Methodist Church —a beautiful structure which looks as if it just grew there—christened by Bishop Schuyler E. Garth, "Wisconsin's Little Cathedral." It speaks handsomely of the dignity of the people of the community and of the reverence with which they view the handiwork of God and the honor of each individual man. The church is designed for worship, for recreation, and for business. The lofty ceiling, the magnificent great window back of the altar, and the wood-framed lamps of the auditorium create an atmosphere of reverence and of great dignity. On the first floor behind the auditorium is a large recreation room with a huge stone fireplace where the members of the church and their friends assemble from time to time for entertainment, and on Christmas to observe the spirit of this great occasion. And here the deacons meet to formulate methods and to provide ways and means of carrying out the functions of this institution which contributes so much to the life and morale of their community. Here too you are made aware of the high idealism and community spirit of Ted and Mrs. Arveson. The lamps of which I spoke were made by Ted in his workshop, and the organ is a memorial to Barbara Jean Arveson.

Like the other institutions of the community, the hospital, a two-story brick building of thirty-bed capacity, is a distinct asset. It is located just off the main street downtown, and a part of the building was constructed earlier by Ted and his partner, Dr. Emma I. Diamond, and used as an office and hospital. Recently an addition has been completed to enlarge the bed capacity. The superintendent of the hospital is a young woman trained in the skills of nursing and possessed of high ideals and capacity for leadership. She has long been an associate of Ted's in his medical ministrations to the community and is imbued with the same community loyalty and leadership as he. The people of the village, from the surrounding areas, and from nearby cities come here to receive all kinds of medical care and the women to have their babies.

In the evening a group of guests were invited in to discuss the topics of the day. The principal of the high school, the director of music for the schools—and it should be said too that the children of the community are supplied with good schools—the minister, business men, and doctors constituted a group of twenty or thirty people. It was a pleasant evening of discussion ranging through national, state, county, and local politics. Not only was the evening a pleasant one, but it was stimulating to be associated with a group who not only enjoy being free citizens but also make a job of it. Their community is an expression of their freedom and leadership to which our friend the doctor has made a large contribution.

This is the solution to the oft-cited "Rural Medical Problems"—medical leadership.

W D Stovall

Estate, Inheritance, and Gift Taxes

Introduction

ESTATES of sufficient size are today subject to at least two taxes during the course of probate, aside from income taxes. One is the Federal Estate Tax which is levied on net estates in excess of $60,000. The second is the Wisconsin Inheritance Tax which is levied on each interest in excess of the statutory exemption which passes by reason of the death of an individual. These state exemptions are in varying amounts, the largest being $15,000 in the case of a widow.

The above two taxes do not take into account the growing trend toward multiple taxation by which is meant the taxation of the same property by two or more states. This trend is checked as between states which have reciprocal statutes. Under the terms of such statutes multiple taxation is avoided by the provision that one state will not tax the property of a nonresident from a second state which in turn has a similar law. The problem is substantial to an increasing number of estates and can greatly reduce the provision which one has made for his family or other beneficiaries, where such person owns property in one or more states outside of Wisconsin which has no reciprocity statute. Such states reach out and tax whatever they can of the property of a nonresident.

Federal Estate Rates

The 1941 federal Revenue Act greatly increased basic estate tax rates with the result that those taxes at least doubled on the first $100,000 of taxable net estate. The 1942 act did not increase rates but did contain important amendments which will affect many estates hereafter. These amendments are summarized below.

Federal estate tax rates vary from 3 per cent to 28 per cent on the first $100,000 of net estate subject to tax, and increase by degrees to a 77 per cent maximum for that portion of any estate in excess of $10,000,000. The increased rates have been effective since September 20, 1941, whereas the 1942 amendments hereafter discussed are effective only as to persons who died after October 21, 1942.

State Inheritance Rates

The only important action of the 1947 Wisconsin Legislature with reference to inheritance taxes was the reenactment of the 30 per cent emergency relief tax computed over and above the normal inheritance tax. The normal tax rate depends upon the relationship of the beneficiary to the deceased and upon the amount received, and varies from 2 per cent to 15 per cent of the amount over and above the exemptions given to the beneficiary. These basic rates are exclusive of the 30 per cent emergency relief tax which was reenacted as above stated.

Importance to Physician and His Family

Like other branches of tax law, those dealing with state inheritance and federal estate taxes are mounting both in their complexity and their rates. The points indicated below are not intended to be comprehensive or exhaustive, but rather to indicate to the physician, in broad outline, some of the general problems involved in those taxes, so as to aid him in planning his estate.

The subject of estate and inheritance taxes is treated in this issue because it bears with increasing directness on the long-term plans of the practicing physician. These taxes must be taken into account when a physician, for example, is making provision for the support of his family, the sale or other disposition of his practice, the collection of his outstanding accounts, and the termination of the partnership arrangement which he may have with one or more associates. The prudent physician cannot disregard in these times the question how his estate and his family will be affected by these taxes.

Gift Taxes Related

Closely related to estate and inheritance taxes, both as a matter of law and rates, are the federal and state gift tax statutes. These are both concerned with voluntary dispositions of surplus funds or other property while the giver is alive. No matter how long they are made before death of the giver, the circumstances of such gifts are carefully analyzed by the federal and state tax authorities to determine whether the gifts were made in contemplation of death. If so, such gifts are then added to the gross estate of the giver for estate or inheritance tax purposes.

I. Federal Estate Tax

The federal estate tax is based on the right of an individual to *give* away the property which he accumulates, as distinguished from the right on the part of his beneficiary to *receive* such property. Among the principal points of interest to the physician in connection with the federal estate tax are the following:

1. *Liability to file return.*—If the gross estate—that is, the total valuation of all assets before deducting debts, expenses of administration, taxes, etc.—is $60,000 or less, no estate tax return need be made by the executor or administrator of the estate of a deceased. If more than $60,000, such a return must be made.

2. *New Exemption of $60,000.* Until adoption of the amendments in October, 1942, the federal law had for a number of years provided an exemption of $40,000 of general assets which were not subject

to estate tax and an additional $40,000 exemption of insurance payable to beneficiaries other than the estate of a deceased person. The 1942 amendment repealed the insurance exemption and increased the general exemption from $40,000 to $60,000. This new exemption includes both insurance payable to the estate and insurance payable to beneficiaries other than the estate on policies on which the insured person has reserved the right to change beneficiaries, as well as other assets.

For the person who has little or no insurance, and whose estate consists of other property, the increased exemption will prove highly favorable. For the person who has $40,000 or more of insurance and in excess of $20,000 in general assets, the 1942 amendments will have the effect of increasing his estate taxes.

Example:

Valuation of gross general assets	$30,000
Amount of insurance payable to estate, or revocably assigned to others	45,000
Gross estate	75,000
Total of debts and deductions	10,000
Net value of estate	65,000
Amount subject to estate tax after deducting $60,000 exemption	5,000

3. *Powers of Appointment.* Each physician would do well at this time to read over his will and see whether it does not call for revision in the light of changed circumstances. One of the points to be noted particularly is the presence of a power of appointment in the will. By this is meant the conferring of authority on another person to designate the person or persons to receive certain of his property. By the terms of a 1942 amendment to the federal act all powers of appointment, except for those to very restricted classes of relatives, are taxable to the estate of the person to whom such power of appointment was given, *even though such latter person might himself have died without ever exercising the power.*

In other words, it is possible under the 1942 amendment for a physician by the phrasing of his own will to impose a heavy tax penalty on the estate of his wife, son, or anybody else to whom he may give a power of appointment, even though such wife, son, or other designated person never derived any benefit whatever from that power and never exercised it in his own favor or that of anyone else.

You should check this matter immediately with your attorney so that you may be sure to come within the exemption of the statute in the event you desire to continue the power of appointment in your will.

4. *Miscellaneous Amendments.* The 1942 federal amendments contain a number of other changes which may hold interest for the physician, one of which concerns charitable pledges founded on a promise or agreement to make a contribution or a gift, so long as the recipient is not an individual and is of a character recognized by the federal statute as being truly charitable. This would include such groups as churches, scientific and educational foundations.

Wills very frequently provide for a bequest of personal property or a devise of real estate to a certain person, under the further condition that if such person should die before receiving the gift, or should for any reason not accept the gift left him by the will, the property so given will go to a charitable organization. One of the new amendments provides that a person entitled to receive a gift by will may renounce or give up his claim irrevocably by a written statement filed prior to the time of filing the federal estate tax return, and that if he does so the property which he would otherwise have received is not subject to tax since it is to go to the charity rather than to him.

Still another of the new amendments provides that if an estate tax is not paid when due the wife or other beneficiary of the estate, including a person having the power of appointment, shall be liable for such tax to the extent of the amount of property which he has received from the estate.

5. *Irrevocably assigned insurance exempt.*—Insurance on the life of a deceased which was irrevocably assigned to beneficiaries other than his estate is wholly exempt from taxation if—

(a) The insurance was not assigned as a gift in contemplation of, or to take effect at, his death.

(b) The beneficiary paid the premiums on the insurance out of funds or his own which did not come to him from the insured either directly or by gift or trust established in his favor by the insured.

By the term "irrevocably assigned insurance" is meant the designation in a policy by the insured person of a person or persons as the beneficiaries of the policy without reservation in the insured of the privilege of changing the beneficiaries at any future date. This has the legal effect of vesting in the beneficiaries irrevocably designated all property rights to the policy.

A 1942 amendment provides that the possibility that a policy may come back into the hands of the insured person and be available to his estate does not destroy what is otherwise an irrevocable assignment.

6. *Joint interests taxable.*—Any property held by a physician and another, or others, jointly, is included in his gross estate to the extent of the physician's title or other interest in such property. Determination of the physician's *actual* interest where that varies from his *declared* interest is subject to technical rules which need not be detailed here. Thus if his *declared* interest as joint tenant in certain land acquired by purchase is shown by the deed to be one-third, whereas his *actual* financial interest is two-thirds, the land will be appraised in the

inventory of his estate at two-thirds of its full value.

This federal administrative practice, in which financial rather than legal considerations control, frequently renders the creation of joint tenancy by a husband in his wife less advantageous as a tax matter than would otherwise be the case. Particularly is this true if the property which is the subject of joint tenancy has substantial value, but does not have a corresponding cash income. An improved farm in normal times is an example of this. For further discussion of the question of joint tenancy, see the subsection of this article entitled "Gift Taxes," at page 42.

7. *New Accounts Receivable Rule.* From the standpoint of the physician one of the most important changes made by the 1942 Revenue Act was the abolition of the accounts receivable accrual rule under which all the uncollected accounts receivable due a physician at the time of his death were given a valuation *both for income and estate tax purposes*, even though none of them were in fact collected at the time of his death, and part of them would never be collected.

The new change in the law provides that such accounts receivable shall not be accrued for income tax purposes at the time of death, but shall be treated as income when and as received by the estate or by some beneficiary of the estate. This is strictly a matter of income taxation, but because it is so closely linked with the cash provision which a physician must make when planning his estate, and because there has been confusion and misunderstanding in the past, the point is again emphasized here.

It should be emphasized that for estate tax purposes a net valuation is *still* placed on the accounts due a physician at the time of his death, just as was true before. The important change is that the income tax on the accounts is payable *only as the accounts are received* instead of being payable by the estate during the course of probate *irrespective* of whether received or not.

II. Wisconsin Inheritance Tax

The Wisconsin inheritance tax is based on the right to *receive* property from the estate of a decedent in contrast to the basis for the federal tax, above noted, which is on the right to *give*. The practical effect of a tax on the right to inherit, such as Wisconsin's, is that each legacy or other share in the estate of a deceased is subject to tax to the extent that it exceeds the statutory exemptions, and the beneficiary gets only the net amount. Thus if a bequest of $5,000 is left by will to a beneficiary, and the inheritance tax on it is $300, such beneficiary will receive only $4,700 from the estate, the other $300 being retained for payment of the tax. This result can be avoided by provisions in the will that designated gifts are to be paid in their full amount to those designated, the estate to pay the amount of the tax. Below are indicated several points which it is hoped will assist the physician in estimating broadly his liability under the Wisconsin inheritance tax law.

1. *Liability to file return.*—Unless it is apparent from the final account rendered by the administrator or executor of an estate to the probate court that the estate is nominal in value, or that the net amount of any share of the estate will fall substantially short of the exemptions allowed by statute, as indicated in paragraph 2 immediately following, every administrator or executor must make an inheritance tax return to the state department of taxation.

2. *Tax exemptions.*—The following amounts received from estates are exempt: $15,000 received by a widow from the estate of her husband; $5,000 received by a widower from the estate of his wife; $2,000 where the relation of the beneficiary to the decedent is that of child, parent, brother, sister, descendent of brother or sister, daughter-in-law, son-in-law, or a child adopted under certain conditions. A $250 exemption is allowed where the relation of the beneficiary to the decedent is that of uncle or aunt or the descendent of an uncle or aunt. An exemption of $100 is allowed where the relation of the beneficiary to the decedent shall be that of any other degree than those stated above, or he shall be a stranger in blood to the decedent.

3. *Insurance exemption of $10,000.*—Under a 1939 amendment, insurance up to $10,000 on the life of a decedent, payable to a beneficiary or beneficiaries other than the estate of the insured is exempt from inheritance tax. This exemption is in addition to that allowed those same beneficiaries if they should receive any of the general assets of the estate, as indicated in paragraph 2 immediately above.

Each beneficiary of such insurance, other than the estate of the insured, is entitled to a portion of the total exemption of $10,000 based on the ratio that the value of the insurance payable to him bears to the value of the total insurance payable to all beneficiaries other than the estate.

Example: Dr. Smith dies and leaves $10,000 in insurance payable to his estate and a $10,000 policy to each of his five children, or a total of $60,000. The $10,000 policy payable to his estate is not included within the $10,000 exemption above, and may be disregarded for purposes of this computation; $2,000 would be exempt on each of the five policies of $10,000 to each of his children, and a tax would be payable on $8,000 of each of those policies. The $8,000 subject to tax in each instance would be added to any other share of such beneficiary in the general assets of the insured's estate and only one tax assessed.

4. *Insurance payable to estate nonexempt.*—No insurance payable to the estate of the insured person is exempt from the Wisconsin inheritance tax. It is included in the general assets of the estate, and whether a tax will ultimately be paid on it will depend entirely on whether the share going to each of the beneficiaries of the estate exceeds the statutory exemption.

5. *Irrevocably assigned insurance exempt.*—Insurance payable on the death of any person which is irrevocably assigned to a beneficiary other than the estate of the insured, so that the insured retains no legal incidents of ownership in such insurance is exempt from inheritance taxation. By "legal incidents of ownership" in an insurance policy are meant the right of the insured or his estate to its economic benefits, the power to change beneficiary, to surrender or cancel the policy, to revoke it for an assignment, to pledge it for a loan, or to borrow on it against the cash surrender value.

The exception to this general rule would be an irrevocable assignment of insurance made by the assured in contemplation of his death, which would be included in his gross estate.

Further applying the statute, if an insurance policy were carried on Dr. Smith's life, even though his wife paid the premiums on the policy out of her own income, the face amount of the policy would be subject to state inheritance tax after the doctor's death, if he had during his life retained any of the "legal incidents of ownership" in the policy as that term is above defined.

6. *Joint interests taxable.*—Any property jointly held by the physician and another or others is subject to tax to the extent of the deceased's declared joint interest in such property.

Unlike the federal tax authorities, the Wisconsin department does not inquire into the *actual* as distinguished from the *declared* interest of joint tenants. Thus, if a wife in fact contributed no part of the purchase price of property of which she and her husband are joint tenants, the state treats the property for tax purposes as if each of them had contributed one-half of the purchase price of such property. From the standpoint of the giver, this is a much more satisfactory administrative arrangement.

Example: Dr. Smith and his wife own as joint tenants a farm worth $20,000 at the time of the doctor's death. Dr. Smith's interest is computed as one-half of that valuation, or $10,000, in his gross estate, and that amount will be deducted from the $15,000 which will be exempt in the hands of Mrs. Smith as his widow for purposes of determining the inheritance tax liability, if any, of such estate.

III. Gift Taxes

There are two ways by which individuals may transfer the title of property other than by sale. The first is by gift while the owner lives; the second, by will, effective upon his death. Some tax aspects of transfers made by will have been discussed in the first two subdivisions of this article. This subdivision is limited to transfers of property made by the owner during his lifetime. Because the state and federal gift tax laws were not enacted until about twenty years after the income tax statutes, and because of the fairly generous exemptions, many people are not aware that gifts which they make call at least for the making of gift tax returns; or that they may result in a gift tax; and that even the payment of a gift tax may not satisfy the authorities folllowing the death of such giver.

1. *Federal.* Any year in which the owner of property gives more than $3,000 to another person, both he and the recipient of such gift must make gift tax returns announcing the fact, date, description and value of such gift prior to March 15 of the following year. Each individual has a lifetime total exemption of $30,000 for all gifts to all individuals, and, in addition, an annual exemption of $3,000 to each person who is the object of his gifts. The annual exemption is noncumulative.

The federal gift tax rates are three-fourths of federal estate tax rates. The giver is liable for the tax, if any, resulting from his gifts. The advantage of making gift tax returns will be not only that the gift tax rates are lower than those of the Estate Tax, but that a money gift, if otherwise valid for tax purposes, comes off the top rate which the estate of the giver would have to pay if he delayed his transfer until after his death. Thus a gift of $5,000 to a son in a particular year would mean a tax of only 2¼ per cent on the last $2,000 thereof, or $45. This same $5,000 might otherwise be taxable at the top rate owed by the estate, which, if only 30 per cent, would be $750, or more than sixteen times as much.

As for joint tenancy under this law, it is believed prudent to report such gifts systematically in each year in which they exceed $3,000, even though no tax may be due because of the lifetime exemption of $30,000 allowed the giver. The very submission of gift tax returns in such cases *may* operate to prevent the federal authorities from denying at a later date that such gifts were valid for tax purposes. This *may* prevent the same authorities from successfully asserting that the value of the property so placed in joint tenancy, for which no actual capital was paid, should be added to the gross estate of the deceased giver. At the very least, if a tax is paid on such a gift during life it would apply against any larger tax which might be found due as a matter of law upon disallowance of such gift. Thus the voluntary payment would not have been money wasted.

It is strongly urged that any person considering making gifts in the form of joint property refrain henceforth, until he has carefully weighed the consequences of his action on its tax side. It is doubtful whether, on tax grounds, joint tenancies should longer be created with the frequency that they have during the past fifteen years, especially where the giver's net estate exceeds $60,000.

2. *Wisconsin Gift Tax.* Under the Wisconsin law, any resident who makes a gift in excess of $1,000 to another person in the course of a given year must so report not later than April 15 of the following year, as must the recipient of such gift. By contrast with the federal gift tax law, it is the

recipient of the gift, rather than the giver, who is primarily liable for the gift tax, if any.

There is a lifetime exemption of $15,000 to the wife; a similar exemption of $5,000 to a husband, and of $2,000 to a child, but no lifetime exemption to any others. In addition, $1,000 per year, non-cumulative, is allowed to *all* recipients of gifts. A gift tax begins at 2.6 per cent on the net amount beyond applicable exemptions, but may not exceed 15 per cent.

The rates are the same as those for estates. While this fact, plus the much lower rates, makes Wisconsin gift tax payments less of a saving than under the federal law, the saving is nevertheless substantial to the extent that each year's gift to a different person has a $1,000 annual exemption, and that the majority of gifts, or at least a portion of them, are taxed at minimum rather than maximum rates provided by the statute.

As for joint tenancies, it is important that the person creating the joint tenancy in his wife or another, where the value of such joint interest exceeds $1,000, report the fact of such gift and the value of the interest.

Agreements of Lease

THE negotiation and signing of leases is an almost universal periodic experience for the physician. If he will observe the precautions indicated below, he may avoid disagreeable experiences and monetary loss.

OFFICE LEASES

A lease is a special type of contract and once general negotiations have been completed, the desirable and prudent policy is to have an attorney draft the instrument itself. This will often prove a much more desirable policy than for the physician to read over hurriedly, and perhaps without full understanding, the printed provisions and rules of a "form" lease, which is generally drafted for the owner's protection rather than for that of the tenant.

The law on the subject of relation of landlord and tenant is a highly involved one and contains a large number of rules. It is thus difficult to generalize those rules, and the effort here made in that direction is intended to *indicate* problems which may quite commonly arise, together with suggested solutions. It must be borne in mind that the remedy in a given case may hinge on the particular facts, or even on a single fact, and that the suggestions above made will have general rather than specific application.

Important Lease Considerations

1. Cancellation of lease by tenant for health or professional reasons. The physician may wish to leave the community, in which he is practicing, for reasons of health or because of a more promising professional opportunity elsewhere. But because his office lease requires him to pay to the end of the term, and no other tenant can be readily procured, he may feel he cannot afford to leave.

Remedy: A clause giving the physician tenant the privilege of leaving for reasons of health, or for professional reasons, may be inserted in the lease with the consent of the owner. Ordinarily, such a provision requires the payment of some additional rent after the physician moves or gives notice of moving, say for thirty or sixty days ahead, so as to compensate the owner against possible vacancy for that period. The owner might reasonably require that in the event of removal for professional reasons, such change of location must not be merely to a place in the same locality, but some specified distance beyond the locality. This and details of notice and causes for moving should all be carefully agreed upon in such a provision.

2. Cancellation of lease following death of physician. The ordinary lease does not terminate on the death of the tenant but is expressly made binding on the tenant's heirs, personal representatives and assigns. This has the legal effect of binding the estate on rental and other obligations. It would seem wise to give the personal representative of a deceased physician (his administrator or executor) the option of limiting or terminating the rental liability of the estate whenever, in his judgment, this should be done.

Remedy: Following is proposed phrasing to carry out this suggestion:

"It is mutually understood and agreed between the parties hereto, that in the event of death of the lessee during the term of this lease, his executors or administrators shall have the option of either terminating the lease or reducing its terms to a month to month rental basis, such privilege to be exercised within 60 days after the executors or administrators qualify as such in proper court proceedings.

"Written notice of termination given to the lessor, or his agent, pursuant to the above agreement shall terminate all liability on the part of the lessee's estate, his administrators, executors or heirs, for rents to be paid for future occupancy of the premises beyond the 30 days next following the service of the notice.

"Any option to renew contained in this lease may be exercised by the executors or administrators of the lessee at the time and in the same manner as provided for the lessee himself, but renewal of this lease will not be implied from any failure of the lessee's representatives to act hereunder."

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3. Decorating of premises. Unless a lease otherwise provides, the owner may not be obligated to do

any decorating of the exterior or interior of leased premises.

Remedy: Questions of decorating leased premises prior to occupancy and during the course of occupancy can easily be handled by appropriate provisions in the lease.

4. **Destruction of premises.** Leases frequently do not provide for the suspension of rent where fire or other casualty has rendered the premises partially or totally unfit for occupancy. Thus a situation may arise, in which the physician cannot continue to occupy the premises following a fire or other serious damage, or can, at best, only occupy them under great difficulty, and yet is compelled to continue full rent payments.

Remedy: The lease should provide that in the event the premises should become wholly untenantable by reason of casualty damage the physician either be immediately released from rental liability or be released following the expiration of a reasonable period required either for the rebuilding of the premises or for the substitution of office facilities in a form acceptable to him. Where premises have been made partially untenantable by reason of casualty damage the lease should provide for a proportionate abatement of rent. Thus if the premises are only 50 per cent usable, there should be a 50 per cent rental allowance until they are fully restored, but any percentage of nonuse over 50 per cent might well be considered as sufficient to excuse any rent payment.

5. **Heating and hot water facilities.** Unless a lease so specifies, the owner may not be obligated to furnish either heat or hot water, both of which are such essential items in a physician's office.

Remedy: Questions both of heating and the furnishing of hot water should be settled at the time negotiations are under way, and then should be carefully set out in the lease itself.

6. **Installations.** A physician may find that the premises he proposes to rent will require additional water and plumbing facilities, and also special gas and electric facilities. The three questions which arise in connection with such installations are: (1) Who has to pay for them initially? (2) Whose property do they become following installation? (3) Must they be removed or the premises restored at the termination of the lease? Such installations are generally costly, and these questions are therefore of substantial importance to the physician tenant.

Remedy: Wherever the plumbing, wiring, or other installations will permanently benefit the premises, the physician should endeavor to arrange that the owner pay so much of the installation cost as possible, and that he pay only the remainder. Wherever such installations are of such a character that they could be removed to other premises by the physician on the termination of his lease, he should reserve in himself the title to and right to remove such installations by terms of the lease itself. In the absence of such a provision, installations will ordinarily be regarded as affixed to the premises and, as such, a part of the real estate. This places title to such fixtures in the owner, and the tenant has no right to remove them on the expiration of the lease. Should the lease be for a period of only two or three years, a substantial investment would have been lost at the termination of that time should the physician be unable or unwilling to renew.

Where the tenant is permitted to remove such fixtures as he has installed, he would ordinarily be expected to restore the walls, floors and other affected parts of the premises to their original condition. This is a reasonable enough provision. Some leases, however, not only give the owner the legal title to such installed plumbing, wiring, etc., but also provide that at the owner's option the tenant may be required to restore the premises to their original condition on expiration of the lease, without being permitted to take away any of the fixtures for which he paid. The tenant should not permit such a provision in the lease.

7. **Public liability coverage.** Many leases contain a clause under which the physician tenant assumes all liability which would normally accrue to the owner of the premises, as, for example, injury to a patient who might be hit by falling plaster in the physician's waiting room while keeping a professional appointment. The average public liability policy does not cover liability assumed under a contract by the tenant but, instead of this, commonly contains a clause substantially as follows:

> *"This policy does not apply to any liability assumed by the assured under any contract or agreement."*

The legal effect of such wording is that the physician is without protection under such a policy although he thinks he has coverage.

Remedy: First, examine the lease to see whether it contains such a provision; namely, that the physician tenant is responsible for any injury received by any person while on the leased premises, even though a defect in the building be its cause. Second, examine the public liability policy carefully. Third, if the policy contains an exclusion of any liability assumed by contract, the physician should then adopt one of the following two courses promptly: (1) arrange with the owner to change the lease provision under which he assumes such liability; (2) if he cannot have the lease modified, have the assumed liability covered by a specific endorsement to be added to the public liability policy.

8. **Renewal of lease.** No lease is automatically renewed unless it contains a specific renewal provision. All indications point to some increase in rental in the years immediately ahead, and the most practical way to hedge against increased rental is by

timely provision in present leases or in leases which may hereafter be signed.

Remedy: If the physician is now under lease, it would be well for him to negotiate with the owner of the premises for a renewal option at this same rental. This provision could be added by mutual consent to the existing lease and would take effect on its expiration, if the option were exercised by the physician according to its terms. Ordinarily, such an option provides that the tenant may renew for an agreed period, at an agreed rental, by giving notice in writing of his intention to do so a certain number of days or months before the present lease expires. Those entering into leases hereafter would do well to include such renewal provisions.

9. **Repairs and upkeep.** The average responsible owner of office space will wish to keep up at least the exterior of the premises so as to prolong its life, minimize fire insurance rates and for other prudent reasons. Such owners are not necessarily willing to keep up the interior of the premises, however. Many leases go a step further and provide that all repairs of any nature which become necessary during the course of a lease are to be at the expense of the tenant. Thus, a physician might take over premises which were old or run down and have to replace such expensive items as the roof, floors, stairs, plumbing, heating plant and wiring during his occupancy.

Remedy: The prospective physician tenant should first make careful inspection of the premises he intends to lease, and come to immediate terms with the owner as to the condition in which they are to be put before he begins occupancy. He should then provide in the lease so far as possible that exterior repairs, such as painting, replacement of rotted boards or steps, or of the roof, be at the owner's expense. A still further provision might well be that repair or replacement of any substantial part of the premises during the lease was to be the obligation of the owner where such repair or replacement was due to ordinary wear and tear rather than to the negligence of the tenant. Still another prudent provision is that all structural repairs, which should include foundations, walls, floors, stairs, and roof, are to be the obligation of the owner rather than of the tenant. These provisions have particular importance where the physician is going to occupy old or outmoded premises.

10. **Subleasing.** Unless a lease makes provision for subleasing of the premises, the tenant has no rights whatever in this respect. A physician desiring to retire from practice might find a highly desirable fellow physician to take over his practice, but he would be helpless in the matter unless the owner approved the subleasing. The same is true in the case of the physician who might wish to leave a community for reasons of health or because of an opportunity elsewhere.

Remedy: Provision should be made in the lease permitting subleasing of the premises after written notice to the owner. The provision permitting the physician to sublease should be as broad as possible, since he might not always be able to find a physician successor. At the very least it should permit him to sublease the premises to another medical practitioner.

11. **Restrictions on leasing.** Upon termination of a lease, and when the physician tenant moves his offices to another location, it is frequently some time before all of his patients become acquainted with the change. If someone else engaged in treating the sick, leases the same space it may mean a loss to the former occupant of many patients referred to him.

Remedy: Urge the inclusion of a clause in your lease restricting the landlord from leasing the premises to another engaged in treating the sick for a period of six months following termination of the lease.

REGISTRATION OF DEATHS

If you are not the attending physician at death but are subsequently called upon to determine the cause of death and file a death certificate, do not look for payment for the examination from public funds. Your fees for the examination are properly a part of the burial expense and your fee arrangement should be with the party responsible therefor. The only payment which can be made to you from public moneys is the usual 25 cent fee for filing the certificate which is paid by the county treasurer upon authorization of the local registrar.

It is especially important to remember this in the event you are asked to perform an autopsy not in conjunction with a coroner's inquest. There is no question as to whether you are entitled to a reasonable compensation for your services, but you cannot look to any state or local governmental unit for payment. See 30 Atty. Gen. 470. Be sure that you are properly authorized before proceeding with an autopsy. See "Coroners and Autopsies," page 82.

Treating the Sick in Wisconsin

Zealous in guarding the sick, and appreciative that the interest of the public health is always the foremost consideration, Wisconsin through its legislature and its courts has accepted the doctrine that to treat the sick is not a right but a privilege—a privilege that must be guarded carefully in the interest of the public. The material presented here is particularly designed for the information of those seeking this privilege in Wisconsin, as well as to provide those who have already secured that privilege with basic information relative to their particular practice and its authorized scope.

For rules and procedure in filing application for licensure as prescribed by the State Board of Medical Examiners, physicians are referred to the secretary of the Board, Dr. C. A. Dawson, River Falls, Wisconsin.

THE BASIC SCIENCE LAW

General

IN 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and diagnosis,[1] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless he has a certificate of registration in the basic sciences, recorded with the county clerk of the county in which he resides.[2] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[3] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.[4]

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the Army, Navy and federal health service,[5] registered nurses,[6] dentists,[7] optometrists,[8] and persons practicing Christian Science or others administering to or treating the sick by mental or spiritual means.[9] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[10] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[11]

The attorney general has ruled that masseurs are not required to qualify under this law, since their licensure provisions impose what amounts to a basic science examination in the limited field of practice of massage and hydrotherapy.[12]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin were granted the opportunity of being registered upon application to the board.[13] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definitions of "Treating the Sick" and "Disease"

Section 147.01 (1), Wisconsin Statutes, 1941, defines what constitutes treating the sick in Wisconsin:

(a) "To treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts.

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis, constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[14] The use of

roentgenography for diagnosis and treatment is treatment of the sick.[15] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[16] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[17]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[18] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[19]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, and all other disbursements by the board, may not exceed in amount the fees received.[20]

Application for Registration

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[21] *The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.*[22]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[23]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[24] The applicant is examined in anatomy, physiology, pathology and diagnosis,[25] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be reexamined in that subject at any examination within one year without further fees, but if he fails in two or more, he must await the passage of one year, and must reapply and be reexamined in all subjects.[26]

An applicant seeking one of the limited licenses, such as for chiropody, need only state to the board that his practice is to be confined to one organ or set of organs, and his examination and certificate are limited accordingly.[27]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[28]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[29] This does not authorize the board, however, to accept the results of an examination conducted by the National Board of Medical Examiners in lieu of its own examination, for the reason that the National Board of Medical Examiners is a voluntary board as distinguished from a board created by law.[30]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.[30a]

The court may then affirm, reverse, or modify the decision of the board.[31]

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[32] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 57, of this article.

LICENSING REQUIREMENTS AND PROCEDURES

General

Under the provisions of the statutes, treating the sick is governed in the following terms:

147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating bodily or mental ailments or injuries of human beings, without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute, nor unless he shall record the same with the county clerk of the county in which

he resides and pay a fee of fifty cents for such recording. Nonresidents shall file such license or certificate in each county in which they shall practice. The clerk shall enter in a book kept for that purpose the date of the license or certificate, the name of the licensee, school or practice shown, and the date of the recording.

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science or by mental or spiritual means;[33] while still another provision exempts from licensure requirements those engaged as commissioned officers of the Army, Navy, or federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[34]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin *may not be pursued as a vocation.* This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[35]

Each specific licensing field in Wisconsin is grouped under one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, osteopathy and surgery, midwifery, massage and hydrotherapy, and chiropody. Section 147.16 of the statutes states that all applicants in these several fields of treating the sick are to be given the same examination, so far as practicable, in the fields of anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation.

There are also licensing boards in chiropractic and optometry, dentistry and nursing. The latter two of these boards will not be discussed in this article, because each embraces a well defined and well regulated professional field, which does not call for extended comment here.

Licensure requirements and procedure, together with the powers of the respective licensing boards, will be treated in the pages following. As a matter of convenience for the reader, the licensing requirements and procedure for the several types of applicants will be summarized under the particular system of treating the sick, rather than by a classification of licensing boards.

Registration

Commencing in 1944 every person licensed to and engaged in or entering upon the practice of medicine and surgery or osteopathy or osteopathy and surgery shall in January of each year register with the Secretary of the Wisconsin State Board of Medical Examiners and shall notify the State Board of Examiners within thirty days of any change of residence or professional address. The fee shall not exceed $3 per year. Each person registering shall receive a printed list of the entire registration. No registration shall be permitted of any one who has been found guilty of any unprofessional act described in Section 147.20 and upon conviction of any of said acts, the registration of such person shall be annulled, subject to his right of appeal. The registry provision shall not apply to physicians serving in the armed forces of the United States or of an allied government.[35a]

Medicine and Surgery

Examining Board.—The examining body for applicants for license to practice medicine and surgery is the State Board of Medical Examiners, which is composed of eight licentiates, appointed by the governor for four-year terms.[36] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[37] The board meets regularly on the second Tuesday of January at Madison, and on the last Tuesday of June at Milwaukee, and at such other times as are considered advisable. At the annual June meeting a president and secretary-treasurer are elected. It is the duty of the secretary-treasurer to receive for the board all money, and to pay it into the state treasury,[38] as well as to keep a record of its proceedings and a register of applications, licenses and certificates of registration issued.[39]

There is appropriated from the state general fund to the board for the execution of all its functions, all money received by it and paid into the general fund.[40] Of this there is allotted to each examiner not more than $10 for each day actually spent, together with actual and necessary expenses, to the board members.[41]

All applications for licensure from the State Board of Medical Examiners must be made to the board at the time and place designated by it, or at any regular meeting.[42]

Educational Requirements.—The applicant must have the equivalent of the premedical course of the University of Wisconsin. Educational requirements of applicants for license to practice medicine and surgery are summarized in Table 1, column 1, page 54.

Each applicant must also file with the board a verified statement that he is familiar with the state health laws and with the rules and regulations of the State Board of Health relating to communicable

diseases,[43] satisfactory evidence of good moral and professional character[44] and proof of the fact that he is twenty-one years of age.[45] An applicant for license to practice medicine and surgery must also present a diploma from a reputable professional college approved and recognized by the board.[46]

The State Board of Medical Examiners has broad discretion in determining the reputability of professional schools,[47] and where it is impossible for the board to determine whether the college is reputable, the burden is upon the applicant to prove its reputability.[48]

In the event the applicant feels that the board was unjust in its determination that the professional school from which he was graduated did not meet its requirements, he may have the determination judicially reviewed in the manner prescribed in Chap. 227, Wis. Stats.[49]

Under no conditions or circumstances may the board issue a temporary license or certificate to an applicant in any system of treating the sick.

Examination and Licensure.—The State Board of Medical Examiners examines all applicants in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation after first satisfying itself that all educational requirements have been met.[50] The board, by rule, may accept a basic science certificate in lieu of any examination in the fields of anatomy, physiology, pathology and diagnosis.[51] In addition to the uniform examination in the above subjects, the applicant is also examined by the board in such further subjects as are usually taught in a reputable medical school.[52] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[53]

This license must be recorded by the physician with the county clerk of the county in which he resides, the recording fee being 50 cents. Nonresidents shall file such licenses in each county in which they practice. Until such license has been issued and recorded, no person may practice or attempt or hold himself out as authorized to practice medicine and surgery.[54] No person who is unlicensed, or who has not recorded his license as above provided, has the right to collect by law any compensation for professional services or to testify in a professional capacity, except in criminal actions, or, under certain conditions, except for nonresident expert witnesses in medicine and surgery, or osteopathy and surgery.[55]

Licensure without Examination.—The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the Army or Navy, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge. The fee for license without examination shall be fixed by the board at not less than the reciprocity fee in the state whose license the applicant presents, but shall in no case be less than $50. A license from another state confers no privilege to practice in this state beyond the right to obtain a license by reciprocity in accordance with the statutes.[56]

Itinerants.—The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners.

Revocation or Suspension of License.—Three procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

(a) By civil action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[57] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of "lost manhood," the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses reestablished, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee, or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betray-

ing a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude.

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[58] Nor is the time within which to bring such action, after the offense has been committed, important.[59] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty, as an accessory before the fact, and his license is subject to revocation or suspension under this section.[60]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[61]

(b) By action of the board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend the license or certificate. The board is likewise under a duty to revoke or suspend any such license or certificate upon proof of a federal conviction of a crime committed in the course of the holder's professional conduct.[62]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[63]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[64] There is no time limitation within which the board must act. In the event, however, that the board suspends rather than revokes the license or certificate, the suspension must be for a definite period not exceeding two years, and the board has the power, upon a proper showing, to restore it at any time within the period. [65a]

The board has no authority to restore a revoked license.[66] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[67]

(c) State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[68] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health.

The statute follows:

The state health officer, the secretary of the state board of medical examiners, and the attorney-general or deputy attorney-general are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under section 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney-general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon.

Osteopathy and Surgery

Examining Board.—The examining board for applicants for a license to practice osteopathy and surgery is the State Board of Medical Examiners, as in the case of applicants for license to practice medicine and surgery (see also page 48).[69]

Educational Requirements.—These requirements are summarized in Table 1, column 2, page 54. Special attention is called to the 1941 amendment providing, in substance, that after June, 1948, an applicant must have had two years of college training, including physics, chemistry, biology and English, in an institution accredited by the University of Wisconsin, and to the 1947 amendment which requires that after June 1948 an applicant must present to the board a certificate of having completed at least twelve months' interneship in a reputable osteopathic hospital, or equivalent training.[70]

Examination and Licensure.—The board examines applicants for license to practice osteopathy and surgery in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, but by rule is also permitted to accept a basic science certificate in lieu of examination in anatomy, physiology, pathology and diagnosis.[71] An applicant must be twenty-one years of age, and must also file a verified statement that he is familiar

with the state health laws and the rules and regulations of the State Board of Health relating to communicable diseases.[72]

In addition to the uniform examination in the above subjects, the State Board of Medical Examiners is further required to examine applicants in branches usually taught in a reputable osteopathic college.[73] It should be noted that the examination does not include materia medica, since applicants in the field of osteopathy and surgery are not trained in this field, as are graduates of medical colleges. If six members of the board find the applicant qualified, it then issues a license to practice osteopathy and surgery, signed by the president and secretary, and attested by the seal of the board.[74]

The license, as in the case of a physician and surgeon, must be recorded with the county clerk of the county in which the licensee resides, and a fee of 50 cents paid for such recording. Nonresidents must file such license in each county in which they practice.[75]

Reciprocity.—The statutory provision relating to reciprocity where osteopaths are concerned is the same as that applicable in the case of physicians and surgeons. See "Licensure Without Examination," page 49.

Itinerants.—The statutory provision appearing under the title "Itinerants," page 49, also has equal application to osteopaths.

Revocation or Suspension.—The same statutory authority, and in general the same case authority and attorney general's opinions having to do with licenses to practice medicine and surgery, have equal application to licenses to practice osteopathy and surgery. See "Revocation or Suspension of License," page 49.

Chiropody

Examining Board.—The State Board of Medical Examiners, as earlier noted, likewise is the examining board for applicants to practice chiropody. See page 48, where the composition of the board is discussed.

Educational Requirements.—Educational requirements for applicants to practice chiropody are outlined in Table 1, column 3, page 54.

Examination and Certificate.—The statutes provide that the State Board of Medical Examiners shall select three registered chiropodists to conduct the examination under its supervision, one of whom is to be appointed as president, and another as secretary, of the chiropody examiners, all three to receive the same compensation as members of the board.

The examination is required to be both scientific and practical, to be written in English, and to cover anatomy and physiology of the feet, diagnosis of the foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, not including any amputation, and the mechanical treatment of congenital or acquired deformities of the feet. The written examination may be supplemented by oral and clinical examination.[76]

If the State Board of Medical Examiners finds the applicant qualified, it shall issue a certificate of registration which is required to be renewed on February 1 of each year upon application and the forwarding of a $2 annual renewal fee to the secretary of the chiropody examiners on or before January 31. Upon receipt of such application, the chiropody examiners are required to send the application fee to the State Board of Medical Examiners for renewal, and the statute levies a renewal fee of $7 against any chiropodist who fails to renew his application on or before January 31 of any year.[77]

The certificate shall be recorded with the county clerk of any county in which the holder practices.[78]

The Wisconsin statutes contain no reciprocity provision for applicants for a certificate to practice chiropody.

Itinerants.—The statutory provisions appearing under the title "Itinerants," page 49, have equal application to itinerant chiropodists.

Revocation of Certificate.—The statute provides that the certificate of registration may be revoked in the manner and for any of the causes set out in section 147.20 which is discussed on page 49. Among additional reasons for revocation of certificate is the failure to reregister before July 1 of any year or for "unprofessional conduct," which term includes the unemployment of solicitors to obtain business, obtaining fees by fraud or deceit, wilfully betraying professional secrets, and the like.[79] The penalties for violation of Chapter 154 relating to chiropody are set out in another section and include fine on the first offense and fine and imprisonment, or both, on a subsequent offense for persons convicted of fraud in connection with a chiropodist degree, practicing under a false or assumed name and similar offense.[80]

Midwifery

Examining Board.—The examining board for applicants to practice midwifery is the State Board of Medical Examiners, and for general information on this body, its composition and general powers, see page 48.

Educational Requirements.—Educational requirements of applicants are summarized in Table 1, column 4, page 54.

Examination and Certificate.—The applicant is required to take a written examination in the anatomy of the female pelvis, anatomy and physiology of the organs contained in the female pelvis, symptoms, diagnosis, physiology and complications of pregnancy, diagnosis, course and management of labor, and care of mother and child for the first ten days.[81]

The examination is required to be prepared and conducted by three members of the State Board of Medical Examiners appointed by the president, and if six members of the board find the applicant qualified it shall grant a certificate of registration, signed by the president and secretary of the board and attested by its seal.[82] The certificate should be recorded by the register of deeds of the county in which the midwife resides or practices, except that in Milwaukee she shall record the certificate with the registrar of vital statistics and pay 50 cents for such recording.[83]

The statutes contain no provision with reference to or the licensing of midwives by reciprocity.

Itinerants.—The general statute appearing under the title "Itinerants," page 49, has equal application to itinerant midwives.

Revocation or Suspension of Certificate.—By statute, the provisions of section 147.20 which relate to revocation or suspension of license of physicians and osteopaths apply to midwives, except for the definition of "immoral or unprofessional conduct." This latter provision is defined by statute to mean in the case of midwives:

(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in her own or any other name in a written or printed paper or document in an obscene manner derogatory to good morals, or advertising means whereby the menses can be regulated, suppressed or reestablished or being in the service of anyone so advertising; (c) indulging in the drug habit; (d) conviction of an offense involving moral turpitude.[84]

Massage and Hydrotherapy

Examining Board.—The examining board for applicants to practice massage and hydrotherapy is the State Board of Medical Examiners.[85] For general information as to the composition and powers of this body, see Examining Board, page 48.

Educational Requirements.—For educational requirements of applicants to practice massage and hydrotherapy, see Table 1, column 5, page 54. In spite of the positive statutory requirement that all persons treating the sick, unless expressly exempt, shall possess a basic science certificate in addition to passing successfully an examination given by the State Board of Medical Examiners in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, the Attorney General of Wisconsin has ruled that a basic science certificate is not a prerequisite to a certificate to practice massage and hydrotherapy, and that opinion has been followed in practice.[86]

The applicant also files a verified statement that he is familiar with the state health laws and rules and regulations of the State Board of Health relating to communicable diseases.[87]

Examination and Certificate.—The statute requires that the applicant be examined by the board in physiology, descriptive anatomy, pathology and hygiene, and that he be further examined in massage and hydrotherapy, under the supervision of the board by a registered practitioner selected by the board and receiving the same compensation as the board members.

If a majority of the board members find the applicant qualified, it shall issue a certificate of registration to practice massage and hydrotherapy signed by the president and secretary and attested by its seal, which certificate shall authorize practice in massage, hydrotherapy, and educational gymnastics, *but not the treatment of a specific disease except upon the advice of a licensed medical physician,* the latter being qualified to practice massage and hydrotherapy by virtue of his license without holding a certificate for the practice of massage and hydrotherapy.[88] The certificate should be recorded by the holder with the county clerk of the county in which he resides and a fee of 50 cents paid for such recording.[89] There is no provision in the statutes for licensing by reciprocity for the practice of massage and hydrotherapy.

Itinerants.—The general statute under the title "Itinerants," page 49, has equal application to itinerant practitioners of massage and hydrotherapy.

Revocation or Suspension of Certificate.—The statutory provisions discussed under the title "Revocation or Suspension of License," page 49, have general application to holders of certificates of registration in the field of massage and hydrotherapy.[91]

Chiropractic

Examining Board.—The examining body for applicants to practice chiropractic shall be the State Board of Examiners in Chiropractic, comprised of three chiropractors appointed by the Governor with the advice and consent of the Senate, who must have been continuous residents and practitioners of chiropractic in the state for the preceding three years, none of whom is an officer or employer, nor financially interested in any school or college of chiropractic, and none of whom is a graduate of any school teaching a method of treating the sick

other than chiropractic. The term of office is six years, and a vacancy shall be filled for the unexpired term. Within thirty days after appointment, the board will meet for the election of a chairman and secretary. Members are compensated at the rate of $10 a day for each day actually spent, and for the actual and necessary expenses incurred in the performance of their official duties.

The board conducts examinations at least twice a year at such times and places as it determines.[92]

Educational Requirements.—Educational requirements for applicants for license to practice chiropractic are summarized in Table 1, column 6, page 54.

Examination and Licensure.—Applicants for license to practice chiropractic must first present a basic science certificate, and are then examined by the State Board of Examiners in Chiropractic, in subjects usually taught in reputable schools of chiropractic.[93] The statute also provides that all licenses issued by the board shall expire on the thirty-first of December following their issuance, except that any holder of a license may have the same renewed from year to year by payment of an annual fee of $5.

The license granted a chiropractor and his basic science certificate must be recorded with the county clerk of any county in which he shall practice or attempt or hold out to practice, and a fee of 50 cents paid for each recording.[95]

The statutes contain no provision with reference to reciprocal licensing.

Itinerants.—The general statute dealing with physicians under the title "Itinerants," page 49, has equal application to itinerant chiropractors.

Revocation or Suspension of License.—The statutes provide that licenses to practice chiropractic shall be subject to revocation or suspension for the causes and in the manner provided in section 147.20.[96] This section refers to revocation or suspension of licenses and certificates issued by the State Board of Medical Examiners or the State Board of Examiners in Chiropractic and the discussion under "Revocation or Suspension of License," page 49, is applicable here.

Optometry

Examining Board.—The examining board for applicants for certificate of registration to practice optometry is the Wisconsin Board of Examiners in Optometry. It consists of five members appointed by the Governor for terms of five years each, each of such appointees to have been a resident of the state, actively engaged in the practice of optometry for at least five years immediately preceding appointment. The board chooses annually from among its members, a president and secretary, each of whom is empowered to administer oaths and take affidavits and to certify thereto under the seal of the board. The board meets at least once every six months at the State Capitol, and on January 1 of each year reports its proceedings to the Governor, including an account of monies received and disbursed.[97]

Educational Requirements.—The educational requirements for applicants are summarized in Table 1, column 7, page 54. The supreme court has recognized optometry as a mechanical art requiring skill and knowledge, but not as a profession, although the fact remains that the conditions to which optometrists apply their skill constitutes "treating the sick" within the meaning of the basic science law.[98] That such was the conclusion of the optometrists themselves follows from the fact that they secured the introduction and supported a specific amendment to secure exemption from the effect of that law.[99]

Examination and Certificate.—The examination, which is required of licensed physicians and surgeons, shall by statute, "relate to such matters as are essential to the practice of optometry" and includes anatomy, physiology, pathology of the eye and its appendages, normal and abnormal refractive, accommodative and muscular conditions and coordinations of the eye, and subjective and objective optometry including the fitting of glasses, the principles of lens construction and adjustment, and such other subjects as the board deems necessary. An applicant who fails at an examination has the privilege of taking another examination upon payment of a $10 fee at any future regular meeting of the board.[100] The board issues a certificate of registration to a successful applicant,[101] which is renewed on or before the first of January of each year on payment of a reregistration fee of $3.[102] Everyone practicing optometry is to display in a conspicuous place at the entrance of his place of business the name of each person so practicing therein.[103]

The holder of a certificate shall present the same or a certified copy to the county clerk of the county of his residence with a fee of 50 cents, and if he moves his residence to, or desires to practice in, another county he shall file a certified copy of the county clerk's record or a new certificate with the county clerk of such county with a fee of 50 cents for each recording before he practices in such other county.[104]

Reciprocity.—One who has been admitted to practice optometry in another state may be issued a certificate at the discretion of the board upon payment of $25; passing an examination by the Board in anatomy and physiological optics; and producing a certificate showing he has passed an examination in such other state and has actually practiced there for five years.[105]

Itinerant Optometrists.—The general statute under the title "Itinerants," page 49, has equal application to itinerant optometrists.

Revocation or Suspension of Certificate—The board may revoke, deny, or suspend a certificate obtained through error or fraud, or where the recipient is grossly incompetent, guilty of immoral or unprofessional conduct, is habitually drunk or addicted to drugs, has been convicted of any optometry law or felony, has continued practice knowing himself to be afflicted with a contagious disease, practices with a person continuing to violate the optometry laws, or has obtained or sought to obtain anything of value by fraudulent representation in the practice of optometry. The statutes also set out the procedure to be followed by the board in preferring charges against the holder of a certificate of registration, together with the procedure on appeal to the circuit court.[106]

One whose certificate has been revoked or suspended may have it regranted to him upon application and satisfactory proof that the cause of revocation or suspension no longer exists.[107] "Unprofessional conduct," as that phrase is used in connection with revocation or suspension of a certificate of registration, is specifically defined by statute, and should be carefully read by interested persons. It includes any conduct of a character likely to deceive or defraud the public; splitting or dividing with any person, other than an associate licensed optometrist, any fee for optometric services; and similar acts.[108]

Prohibited Advertising

It is unlawful to advertise directly or indirectly any definite or indefinite price or credit terms on lenses, frames, complete glasses or any optometric services; to advertise in a manner that will tend to mislead or deceive the public; to solicit patronage by advertising that he or some other person or group

TABLE 1.—*Wisconsin Educational and Other Requirements Preliminary to Examination for License to Treat the Sick (Excluding Dentistry and Nursing)*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
1. Medicine and surgery (Secs. 147.15; 147.17 (1))	Equivalent to graduation from an accredited high school of this state.	Equivalent of the pre-medical course at University of Wisconsin, including physics, chemistry, biology and either German or French.	Diploma from reputable professional college; good moral and professional character; applicant to be 21 years of age.	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital.	$20 with an additional $5 if license is issued.
2. Osteopathy and surgery (Secs. 147.15;147.17(1))	Equivalent to graduation from an accredited high school of this state.	After June, 1948, 2 years' college work including physics, chemistry, biology and English in an institution accredited by University of Wisconsin.	Diploma from reputable professional college; good moral and professional character; applicant to be 21 years of age. Internship of at least twelve months in a reputable osteopathic hospital, or equivalent training.	None	$20 with an additional $5 if license is issued.
3. Chiropody (Sec. 154.02)	Equivalent to graduation from an accredited high school.	One year in a recognized college of liberal arts or science, since July 1, 1940.	Completion in a reputable school of chiropody, a course at least equivalent to 3 years of 37 weeks of 30 class hours each, in anatomy and physiology of the feet, and diagnosis of foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, minor surgery and bandaging pertaining to ailments of the feet and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must be of good moral and professional character and more than 21 years of age.	None	$20
4. Midwifery (Sec. 150.02)	None	None	Diploma from a reputable school of midwifery which is a school connected with a reputable hospital or sanatorium giving at least a 12 months' course in the science and practice of midwifery and practical experience in at least 20 cases; good moral and professional character.	None	$10 with an additional $5 if certificate is issued.
5. Massage and hydrotherapy (Sec. 147.185)	Equivalent to graduation from an accredited high school of this state.	None	Completion, in a scientific or professional school, of an adequate course in physiology, descriptive anatomy, pathology, and hygiene; good moral and professional character.	None	$20 with an additional $5 if certificate is issued.
6. Chiropractic (Sec. 147.23(3))	Equivalent to graduation from an accredited high school of this state.	None	Diploma from a reputable school of chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class hours; good moral character.	None	$25
7. Optometry (Secs. 153.04; 153.05)	High school education or its equivalent as determined by the board.	None	Graduation from an accredited college of optometry approved and recognized by the Board maintaining a course of study not less than four academic years, each year consisting of 36 weeks of classroom work or an aggregate of 4,000 hours of actual instruction in such college. Applicant must be 21 years of age to write examination.	None	$25 for application, plus $10 for subsequent examination in the event of failure.

possesses superior qualifications or are best trained to perform the service; or to render any optometric services pursuant to such advertising.[109]

Citations

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1947 Wisconsin statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 147.01 (1), (c).
[2] Sec. 147.02; 147.14 (1).
[3] Sec. 147.14 (1).
[4] Sec. 147.04.
[5] Sec. 147.02; Sec. 147.19 (1).
[6] Sec. 147.02.
[7] Sec. 147.01 (2).
[8] Ibid.
[9] Sec. 147.02; Sec. 147.19 (2).
[10] Sec. 147.02; Sec. 147.19 (1).
[11] Sec. 147.02; Sec. 147.19 (1).
[12] 26 Atty. Gen. 591, (1937).
[13] Sec. 147.09; 23 Atty. Gen. 87.
[14] Nickell v. State, 205 Wis. 614.
[15] 16 Atty. Gen. 560.
[16] 20 Atty. Gen. 107.
[17] 21 Atty. Gen. 1135.
[18] Sec. 147.03.
[19] Ibid.
[20] Sec. 147.12.
[21] Sec. 147.05.
[22] Sec. 147.06.
[23] Sec. 147.05; 22 Atty. Gen. 297.
[24] Sec. 147.06.
[25] Ibid.; Sec. 147.01 (1), (c).
[26] Sec. 147.07.
[27] Ibid.; 32 Atty. Gen. 340.
[28] 26 Atty. Gen. 110.
[29] Sec. 147.08.
[30] 23 Atty. Gen. 303.
[30a] Sec. 147.11.
[31] Sec. 227.20 (1).
[32] Sec. 147.10.
[33] Sec. 147.19 (2).
[34] Sec. 147.19 (1).
[35] Sec. 147.14 (1).
[35a] Sec. 147.175.
[36] Sec. 147.13 (1).
[37] Ibid.
[38] Sec. 147.13 (2).
[39] Sec. 147.13 (5).
[40] Sec. 20.44 (1).
[41] Sec. 2044 (1), (a).
[42] Sec. 147.15.
[43] Ibid.
[44] Ibid.; State ex rel. Dubin v. State Board of Med. Exam., 222 Wis. 227, 233.
[45] Sec. 147.17 (1).
[46] Sec. 147.15.
[47] 19 Atty. Gen. 537; 25 Atty. Gen. 459.
[48] 25 Atty. Gen. 459; 26 Atty. Gen. 420.
[49] Sec. 227.16.
[50] Sec. 147.16.
[51] Sec. 147.04.
[52] Sec. 147.16.
[53] Sec. 147.17 (1).
[54] Sec. 147.14 (1).
[55] Sec. 147.14 (2).
[56] Sec. 147.17 (1); 28 Atty. Gen. 685, 686.
[57] Sec. 147.20 (2).
[58] 12 Atty. Gen. 144; State v. Lewis, 164 Wis. 363.
[59] State v. Schaeffer, 129 Wis. 459, 467.
[60] 24 Atty. Gen. 108.
[61] 18 Atty. Gen. 289; 21 Atty. Gen. 476.
[62] Sec. 147.20 (3).
[63] 18 Atty. Gen. 289.
[64] 26 Atty. Gen. 378.
[65] 30 Atty. Gen. 43.
[65a] Sec. 147.20 (5).
[66] 2 Atty. Gen. 571.
[67] Sec. 147.20 (4); 22 Atty. Gen. 942.
[68] Sec. 147.195.
[69] Sec. 147.14 (1).
[70] Sec. 147.15.
[71] Sec. 147.16; Sec. 147.04.
[72] Sec. 147.17 (1); 147.15.
[73] Sec. 147.16.
[74] Sec. 147.17 (1).
[75] Sec. 147.14 (1).
[76] Sec. 154.03.
[77] Sec. 154.04.
[78] Ibid.
[79] Sec. 154.05.
[80] Sec. 154.06.
[81] Sec. 150.03.
[82] Ibid.; Sec. 150.04 (1).
[83] Sec. 150.04 (2).
[84] Sec. 150.05 (2).
[85] Sec. 147.185.
[86] Sec. 147.02; Sec. 147.04; Sec. 147.16; 26 Atty. Gen. 591.
[87] Sec. 147.185.
[88] Sec. 147.185; 28 Atty. Gen. 685, 686.
[89] Sec. 147.14 (1).
[91] Sec. 147.20.
[92] Sec. 147.23 (2); Sec. 147.23 (4).
[93] Sec. 147.23 (4).
[95] Sec. 147.23 (1).
[96] Sec. 147.23 (6).
[97] Sec. 153.02 (1); 153.03 (1), (2), (3).
[98] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[99] Sec. 147.01 (2).
[100] Sec. 153.04.
[101] Sec. 153.04.
[102] Sec. 153.06 (1).
[103] Sec. 153.06 (2).
[104] Sec. 147.04 (1).
[105] Sec. 153.05 (2).
[106] Sec. 153.07; 153.08; 153.09.
[107] Sec. 153.09 (2).
[108] Sec. 153.08.
[109] Sec. 153.10.

Legal Limitations on Licensure to Treat the Sick

ONLY persons licensed to practice medicine and surgery are comprehensively trained, and may use any modality they choose in the treatment of the sick. All other licentiates are limited in the scope of their practice.

Use of the Title "Doctor"

Section 147.14 (3), Wis. Stats., 1947, provides that:

No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under section 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M. D.," "D. O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick.

In addition to physicians and osteopaths, who are expressly mentioned in the above statute, only those licensed to practice dentistry, by virtue of express statutory permission, may use the title "doctor"[1] in the field of treating the sick.

The attorney general over a period of many years has ruled that the use of the title "doctor" alone, or in combination with any other phrase, whether modifying in character or not, is barred to all but those licensed to practice medicine and surgery, osteopathy and surgery, or dentistry. Optometrists, while not engaged in the practice of medicine,[2] are engaged in treating the sick, as they themselves conceded in asking to be excluded from the requirements of the basic science law;[3] the use of the title would effectively misrepresent their qualifications as the supreme court has recognized by holding that they are but skilled tradesmen.[4] Chiropodists are entitled to use the designation "R. C.,"[5] but they are not "doctors." Masseurs are registered with the State Board of Medical Examiners and use the designation "R. M.," indicating that they are registered masseurs, but they are not "doctors," nor may they otherwise classify themselves.

The supreme court of Wisconsin has upheld numerous opinions of the attorney general ruling that the Wisconsin law forbids the use of the title "doctor" by chiropractors. In a recent opinion[6] by Chief Justice Rosenberry, the court held that such use:

. . . would tend to lead the public to the conclusion that persons so announcing themselves were qualified physicians, surgeons, or osteopaths as well as chiropractors. The situation is not aided because as was stipulated the defendant claimed he explained to his patient the nature of his treatment before administering it. *The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment* . . . (Italics ours)

Chiropractors

"Chiropractic" is defined as:

. . . The adjustment of, ordinarily, the spinal column, and ordinarily only by manipulation by the hand; also, that chiropractic does not include the use of any medicines or drugs, nor surgery, nor the use of any devices which do other than adjust, if, indeed, it permits mechanical apparatus even for adjustment.[7]

Chiropractors have advertised themselves as devoted to a theory that their practice is "a philosophy, science and art of things natural; a system of *adjusting* the articulations of the *spinal column, by hand* only, for the correction of the cause of disease. This definition is inclusive and any and all other methods are declared not to be chiropractic. All else belongs to other methods."[8]

Licensed only as chiropractors, the practice of these cultists is limited to chiropractic. This is a proper ruling, since to "permit them to do more than that is to turn loose a group of incompetents in the use of methods for which they are incompetent, and work a hardship on the public."[9]

Restrictions on Chiropractic Practice.—Chiropractors in Wisconsin are not available for the treatment of workmen's compensation cases, for a chiropractor "is not a physician as that term is used in the (compensation) act and in chapter 147."[10] One licensed only as a chiropractor in Wisconsin, who uses electrotherapy in the course of treatment violates the Medical Practice Act.[11] Nor can chiropractors administer medicines or drugs, nor use any therapeutic methods other than adjustment of the spinal column by hand.[12] Chiropractors are not privileged to disregard the quarantine of communicable diseases, as they are not physicians under the Wisconsin law.[13] A chiropractor is not permitted to perform electrocoagulation of the tonsils.[14] Not being a physician, he cannot sign death certificates,[15] or, by analogy, other health records.

Osteopaths

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[16]

Applicants in this particular field, who demonstrate the necessary qualifications, have been licensed since 1916 to practice osteopathy and surgery. A person licensed before 1916 to practice osteopathy alone is licensed to practice surgery upon presenting satisfactory evidence of having completed the course in surgery at a reputable osteopathic college, requiring not less than twenty

months' actual attendance, and the regular examination of the board in surgery, and upon being found qualified by six members of the Board of Medical Examiners.[17]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[18] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[19]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so . . ."[20]

It follows from this line of reasoning that osteopaths, not being licensed to practice medicine, cannot give the "medical examinations" required in cases of admission to state sanatoriums and county tuberculosis hospitals,[21] nor can an osteopath certify to the Wassermann examination as required under the Wisconsin marriage laws.[22] Under a recent opinion of the attorney general, osteopaths may not give injections for arthritis, although they may administer rectal anesthetics, if licensed in surgery, in connection with an operation.[23]

Masseurs

One licensed to practice massage or hydrotherapy is authorized to practice in those two fields, or in educational gymnastics, but not to treat a specific disease, except upon the advice of a licensed medical physician.[24] Massage has been defined as "a system of remedial treatment consisting of manipulating a part or the whole of the body with the hands or by mechanical means," while hydrotherapy is the use of water for therapeutic purposes.[25] An opinion of the attorney general used the following definition: "a method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[26]

It has been held that one giving athletic rubs in a club in connection with athletics or physical exercise is not required to be licensed to practice massage or hydrotherapy as such a license is applicable only to the practice of massage for therapeutic purposes. The attorney general has more recently held, however, that a massage parlor for reducing purposes only must be operated by one licensed as a masseur.[27]

Midwives

A midwife is not authorized to use any instruments, except to sever the umbilical cord, and may not assist childbirth by artificial, forcible or mechanical means. The performance of version, removal of adherent placenta, is likewise forbidden her as is the administering, prescribing, advising or employing of any drug, herb or medicine other than disinfectant and ergot after redelivery of the placenta. A midwife is unauthorized to practice medicine, surgery or osteopathy, or assume any title or designation tending to show that she is a practitioner of medicine or by law so recognized or authorized to grant any medical or death certificate.[28]

A midwife is further restricted from giving prenatal care.[29]

Optometrists

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaption of lenses, prisms and mechanical therapy for the aid thereof.[30] It is a mechanical trade not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient."[31]

Chiropodists

The practice of chiropody permits the diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of abnormal nails or superficial excrescences on the hands and feet, such as corns, warts and callouses, or fissures and bunions; the diagnosis or mechanical but not surgical treatment of congenital or acquired deformities of the feet, but *does not* include surgical operations upon the hands or feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local. It *does not* permit incisions involving structures below the skin, nor of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg in so far only as they are involved in the enumerated conditions of the feet.[32]

Enforcement

The 1941 Wisconsin Legislature transferred the obligation of enforcing the Medical Practice Act from the State Board of Health to the State Board of Medical Examiners.[33] Funds for enforcement of the Medical Practice Act are now secured from the $3 annual registration fee provided for by Section 147.175, which was enacted in 1943.

Anyone violating any provision of the Act "shall be fined not less than one hundred nor more than five hundred dollars, or imprisoned not less than sixty days nor more than one year, or both."[34]

Citations

Note: All references below, beginning with the abbreviation "Sec.," are from the designated chapters and sections of the 1947 Wisconsin Statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. All references containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 152.02 (1).
[2] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[3] Sec. 147.01 (1), (a), (b); 147.01 (2)
[4] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[5] Sec. 154.01 (2).
[6] State v. Michaels, 226 Wis. 574, 579, 580.
[7] 21 Atty. Gen. 646, 651; 29 Atty. Gen. 420, 421.
[8] Advertisement of Wisconsin Chiropractic Association, Appleton Post Crescent, October 6, 1931.
[9] Statement of B. J. Palmer, of Davenport, Iowa, founder of chiropractic, to the attorney general of Wisconsin, September 6, 1932.
[10] Corsten v. Industrial Commission, 207 Wis. 147, 148.
[11] 21 Atty. Gen. 646, 652.
[12] 29 Atty. Gen. 420
[13] 7 Atty. Gen. 68, 69; 14 Atty. Gen. 442.
[14] 17 Atty. Gen. 318, 319.
[15] 16 Atty. Gen. 95.
[16] Herzog, Medical Jurisprudence, Sec. 121, and Arnold v. Schmidt, 155 Wis. 55, 61.
[17] Sec. 147.17 (1).
[18] 10 Atty. Gen. 837; 29 Atty. Gen. 148.
[19] 14 Atty. Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163.
[20] 29 Atty. Gen. 148, 153.
[21] Chap. 50, Wis. statutes.
[22] Sec. 245.10.
[23] 29 Atty. Gen. 420.
[24] Sec. 147.185.
[25] Herzog Medical Jurisprudence, Sec. 125, 128.
[26] 28 Atty. Gen. 685–686.
[27] 26 Atty. Gen. 61; 29 Atty. Gen. 297.
[28] Sec. 150.04 (3).
[29] 26 Atty. Gen. 236.
[30] Sec. 153.01.
[31] State ex rel. Harris v. Kindy Optical Company, 235 Wis. 498, 501.
[32] Sec. 154.01 (1).
[33] Sec. 147.13 (6).
[34] Sec. 147.21.

Cooperative Health Associations Enabling Act

Sections 185.25 to 185.29 of the Wisconsin Statutes

185.25 Co-operative sickness care. (1) Co-operative associations may be organized under this chapter without capital stock, exclusively to establish and operate in the state or in any county or counties therein a nonprofit plan or plans for sickness care, including hospital care, for their members and their dependents through contracts with physicians, medical societies, dentists, dental societies, hospitals and others.

(2) Such associations shall operate only on a co-operative nonprofit basis and for the purpose of establishing, maintaining and operating a voluntary non-profit medical or dental care plan or plans or for constructing, operating and maintaining nonprofit hospitals whereby sickness or hospital care is provided at the expense of such association to such persons or groups of persons as shall become subscribers to such plan under contracts which will entitle each such subscriber to definite medical, surgical, dental, or hospital care, appliances and supplies, by physicians and surgeons licensed and registered under section 147.175, or by dentists licensed under section 152.05 in their offices, in hospitals and in the home.

(3) No co-operative association organized for the purposes provided in sections 185.25 to 185.27 shall be prevented from contracting with any hospital in this state for the rendition of such hospital care as is included within such a plan because such hospital participates in any other such plan, or in a plan organized and operated under the provisions of section 180.32. No hospital may discriminate against any physician and surgeon or dentist with respect to the use of such hospital's facilities by reason of his participation in a sickness care plan of a co-operative.

(4) No contract by or on behalf of any such co-operative association shall provide for the payment of any cash, indemnity or other material benefit by that association to the subscriber or his estate on account of death, illness or injury, nor be in any way related to the payment of any such benefit by any other agency, but any such association may stipulate in its plan that it will pay any nonparticipating physician and surgeon, dentist or hospital outside of its normal territory for sickness or hospital care rendered any covered member or his covered dependent who is in need of the benefits of such plan when he is outside of the territory of such association in which the benefits of such plan are normally available. Any such plan may prescribe monetary limitations with respect to such extra-territorial benefits.

(5) Every such co-operative association is hereby declared to be a charitable and benevolent corporation, and its property, real, personal and mixed, its income and property transferred to it, shall be exempt from taxation as provided in sections 70.11, 71.05, 72.04 and 72.75, and its employes shall be excluded from the provisions of chapter 108 as provided in section 108.02.

185.26 Manner of practicing medicine; payment; promotional expense. (1) No sickness care plan or contract issued thereunder by such co-operative association shall interfere with the manner or mode of the practice of medicine or dentistry,

the relationship of physician or dentist and patient, nor the responsibility of physician or dentist patient. Any person who is covered by any such plan shall be free to choose for sickness care any medical or osteopathic physician or dentist licensed to practice in Wisconsin who has agreed to participate in such plan and abide by its terms, and no such physician or dentist shall be required to participate exclusively in any such plan. Except for professional cause, no such co-operative association shall deny to any duly licensed physician or dentist the opportunity to participate in such a plan who agrees to participate therein according to its terms.

(2) Any co-operative association operating a voluntary sickness care plan under the provisions of this chapter may pay physicians and surgeons, or dentists on a salary, per capita or fee-for-service basis to provide sickness care to members of such association. No such payment shall be made on a percentage basis of work done, nor shall any such association retain any part of the physician's or dentist's fee if a fee-for-service payment basis is used to provide members with such sickness care service. Every association shall contract only with its own members for the benefits of any plan which it operates, but any association which operates a hospital may make the facilities thereof available to non-members and to nonparticipating physicians or dentists.

(3) Promotional expenses of any such association, including promotional expense for building or investment purposes, shall be limited to 5 per cent as provided in section 185.21.

185.27 Requirements of plan. (1) Every such voluntary nonprofit sickness care plan shall be exempt from the state insurance laws but the sponsoring association shall:

(a) File with the commissioner of insurance a declaration defining the organization and operation of the plan, all printed literature and specimen copies of all proposed contracts with persons covered and with participating physicians and hospitals, including all amendments thereto. The form of all such contracts and amendments shall be subject to approval by the commissioner of insurance but the commissioner may not withhold approval if the form of such contracts or changes therein comply with the provisions of sections 185.25 to 185.29.

(b) Provide for like rates, benefits, terms and conditions for all persons in the same class.

(c) Invest its funds only in property and securities approved for domestic life inurance companies.

(d) File with the commissioner of insurance, on such forms as may be prescribed by him, an annual report of its financial condition as of December 31 each year, on or before the last day of February following.

(e) Maintain sufficient reserves to discharge its obligations, having regard for the nature of its contracts and the area and number of persons covered.

(2) Every such plan shall make provision for a minimum of one physician and surgeon, or dentist to each 2,000 persons covered for medical or dental care and a minimum of 6 hospital beds for each 2,000 persons covered for hospital care.

185.28 Authority to enjoin unlawful operation. The books and records of any co-operative association establishing and operating any sickness care plan under the provisions of sections 185.25 to 185.27 shall at all times be subject to examination by the commissioner of insurance. If at any time the commissioner shall find that any such sickness care plan does not comply with the provisions of sections 185.25 to 185.27 the commissioner shall direct said co-operative to comply with said provisions. In the event that any co-operative association fails to comply with such order, the commissioner may commence an action in the circuit court in the county where the principal office of said co-operative association is located for the purpose of enjoining the continued operation of said plan. If the court shall find that said co-operative association or the sickness care plan or plans being operated by it do not comply with the provisions of sections 185.25 to 185.27 in such a material manner as to jeopardize the rights of member subscribers to receive the benefits to which they are entitled, it may enjoin the continued operation of such association or plan.

185.29 Inconsistent provisions of the statutes. Sickness care or hospital plans operated by co-operative associations organized under this chapter shall be operated exclusively under the provisions of sections 185.25 to 185.29. Other provisions of the statutes inconsistent with any of such provisions shall not be applicable to co-operative associations or sickness care plans operated by co-operative associations pursuant to this chapter.

Fee Splitting

Introduction

SINCE 1913, the Wisconsin statutes have forbidden fee splitting by physicians. See section 343.322 of the statutes. Likewise, the profession itself has long frowned on the practice, as has the American College of Surgeons in its *Manual of Hospital Standardization*, published in 1946. At page 19 is set forth "Principles of Financial Relations in the Professional Care of the Patient." This statement of principles makes it very clear that the practice of fee splitting is deemed professionally undesirable even in those states which do not specifically prohibit it. Further, the Manual has as a part of its requirements the adoption by each hospital of a resolution against the practice in which must join all physicians who have hospital privileges. Fee splitting is unreservedly condemned, and a hospital in which

this practice is known to exist cannot secure or retain a place on the approved list.

It has been said that fee splitting actually means "the buying and selling of patients on a commission basis." The direct effect of fee splitting is that the patient is deceived into thinking that the statement rendered by the physician is for services rendered by him alone. In fact it might include a fee for forwarding the patient or for services rendered by one or more other physicians. The vice is not so much that the patient pays more when the fee is split, but that he does not know all of the parties whom he is paying. Of course, the practice lends itself to overcharging the patient when the splitting of the fee is made as a reward for sending the patient to the physician who actually does the work.

In 1914 the attorney general, Hon. Walter C. Owen, later a member of the Wisconsin supreme court, was asked for an official opinion interpreting the fee-splitting statute and indicating its effects. Below are stated the eight questions which he was asked to answer, together with a summary of his opinion which appears in volume 3 of the *Opinions of the Attorney General of Wisconsin*, at page 218. This opinion was approved and reaffirmed by a later attorney general in 1935. (See volume 24, *Opinions of the Attorney General of Wisconsin*, page 580.)

Attorney General's Opinion

1. *Under the law as it now stands, can a surgeon, not a member of the regular staff of a hospital, operate at such hospital for a stated fee for the institution and let the hospital collect the surgical fee from the patient according to his ability to pay along with other hospital fees; the hospital paying the surgeon the fee agreed upon, whether larger or smaller than the fee charged the patient by the hospital, or must the surgeon, under the circumstances, charge the fee for the operation direct to the patient?*

While the law does not specifically make it an offense for a hospital to employ a surgeon who is not a member of its regular staff to perform a particular operation under an arrangement that the hospital make its charge to the patient for such operation or treatment and that it make its charge for such surgical services irrespective of the amount paid by it to the surgeon, yet it would seem that the evils incident to such a practice would be as great as in the case of fee splitting between two physicians or surgeons.

2. *Where a surgeon operates at a hospital in which he has a financial interest, or in which he is part owner or sole owner, but conducts the business in the name of the hospital, must he make a separate charge for operation or may the whole charge be made by and in the name of the hospital?*

The hospital may employ a physician or surgeon upon salary and then make a contract with the patient to furnish him both medical or surgical treatment and hospital service. If this is done, the entire charge could be made in the name of the hospital. If, however, the physician or surgeon is not paid a salary, but charges separately for each treatment or each operation, the safer practice is to make the charge for medical services direct to the patient and let the hospital make its charge separately to the patient.

The attorney general was asked in the same opinion to answer the three questions which follow, and in each case did so with the statement that the safer practice under any of the above circumstances is for the surgeon to make his charge *direct* to the patient, or to phrase it otherwise, for the *consulting* surgeon to make a contract with the patient which is separate from that between the *original* physician and the patient.

3. *Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?*

4. *Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician, can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?*

5. *Under these conditions, can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?*

The attorney general was also requested in this opinion to answer the three remaining questions set out below, and again stated as his opinion that the physician's and surgeon's charges should be made *direct* to the patient and that no part of the fee received by the surgeon or hospital should be paid to the physician advising the operation or treatment.

6. *Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?*

7. *Can a surgeon charge a regular fee for operations to a physician, including fee for operating room, dressings, anesthetic, etc., irrespective of the ability of the patient to pay, and the physician in charge of the case collect his fee, including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician?*

8. *If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?*

While the attorney general's opinion does not have the same authoritative standing as a decision of the state supreme court, for example, it is important as

the official expression of the highest non-judicial legal officer of the state, and both the courts and the legislature have in many cases accorded substantial standing to such opinions.

Effect on Partnerships and Clinics

Although there is no law on the matter in Wisconsin, and the attorney generals' opinions have not thus far ruled on the point, it is believed that the statute, as phrased, does not forbid the formation of medical partnerships and clinics, or the rendition of a *single* bill for services performed by more than one physician in either organization. It is believed that this is a *permitted exception* to the fee-splitting statute even though two or more physicians in a given partnership or clinic may have rendered services to the same patient in connection with the same general examination or ailment. That is believed to be the *only* exception, however, contained in the Wisconsin statute, and the probable reason for it is that the factual arrangements between two or more physicians in a partnership or clinic are open and generally known instead of being concealed and indeterminate. A secret partnership formed to evade the fee-splitting statute is undoubtedly in violation of that law.

Malpractice and Malpractice Suits

EVERY malpractice action undermines the confidence of the public in physicians, and it is said that other suits are commenced, based upon the publicity given a new case. A careless statement or a neglected clinical routine is most frequently the cause of a misunderstanding which leads to the trial court. Each physician owes to his profession and to himself the duty of maintaining a justified public confidence in medicine. The vast majority of all malpractice actions could have been averted had the physician followed a few common sense precautions and office routines.

Causes For Misunderstanding

1. Medicine is a science, but its proper application is largely an art. It is unwise to make unnecessary positive statements, particularly in early diagnosis or treatment in the broad field of human ills. When you say, "It is nothing but a cold; take these, go back to work and forget it," and subsequently it is found that the patient had incipient tuberculosis at the time he saw you, he is sure at least to resent your too-positive attitude if nothing more.

2. Few of the laity understand that an exact anatomic alignment in a fracture is not usual or necessary; that you are trying to attain it but that you are primarily interested in the functional result. When this is not explained and the patient subsequently sees an x-ray film showing only a fair anatomic result, who is to blame him if he fears he has had poor treatment? Frankness in explaining at least something of this to "fracture patients" is urged; then they will at least appreciate the difficulties that beset the paths of the best of men and will be thoroughly satisfied to find a good functional use restored.

3. The physician who promises quick results and fails to attain them frequently finds his patient seeking another physician.

4. Attorneys frequently say that street corner advice is worth just what one pays for it, yet it occurs with a fair degree of frequency that an attorney will ask a physician for street corner advice on a supposed course of treatment. Be careful what you say for he may be trying to arrive at conclusions whether a client has a real malpractice case. What he tells you will likely be but one side of the case and when all is known to you, your first opinion may be reversed.

5. In these days of compensation insurance a new cause for misunderstandings between physicians exists. It is an everyday occurrence for insurance carriers to demand that their physician see the insured. Such physician may occasionally make a report which is critical of the family physician and the insurance company may use this report to demonstrate to the claimant that his period of recovery was prolonged by the treatment of the family physician and that the company could not be expected to pay for the entire period of recovery. Again it is suggested that the second physician be sure he is in possession of all the facts before he makes a report critical of the family physician. If the family physician did his work carefully and exercised the same degree of skill as other practitioners in the community he will not be found guilty of malpractice even though better treatment might have been had in a distant, large hospital with more adequate facilities.

6. When a patient does not pay his bill, and the ability to pay appears to exist, many physicians turn the bill over to a collection agency which may start suit in a physician's name. The man who does not pay his just debts within a reasonable period of time when ability to pay exists, is frequently not a man of honor or character. Such a man may bring a counterclaim alleging malpractice as a means of blackmailing the physician into dropping the original action for collection of fees. Indeed, records show a fairly large percentage of malpractice suits are begun as counterclaims rather than as original actions. The understanding physician, appreciating the danger in counterclaims on the part of the unscrupulous, will watch carefully that bills of such persons are not pressed unduly until after two years have passed following the last treatment. This generally means an added delay of but a few months and is a wise precaution when dealing with the type of people mentioned. After two years, malpractice is outlawed, but the statute of limitations still allows four years more in which to collect the debt.

7. No physician should pass over a case of definitely suspected fracture, dislocation or foreign body without advising roentgenograms to make certain the diagnosis, if it is impossible by the unaided senses to exclude these conditions. Failure to give such advice may lead to a malpractice suit.

8. The law does not require you to respond to a call by anyone who applies. But after you have once accepted employment, you assume responsibilities with respect to attendance that continue throughout employment. If you yourself desire to terminate those responsibilities, you may,—provided you give reasonable notice, in view of the condition of the patient, as will permit the patient to employ another attendant. This is a general rule of law; its applicability will vary as to each case.

Routine to Be Followed

Certain precautions should be followed as a routine if a physician desires to take every precaution to avoid malpractice actions.

1. Every roentgenogram should show the patient's number, the date, and at least the initials of the operator. The patient's record should show clearly the number of roentgen ray exposures.

2. In the case of fluoroscopic examinations the examiner should by all means note on the patient's record at the time the length in time of examination under the rays and the setting of the machine.

3. Do not put your faith in "fool-proof" apparatus. Have your equipment, such as your roentgen ray and fluoroscopic machines inspected regularly, for the assurance of the maker is no protection to you if something goes wrong.

4. Take no roentgenograms; do no fluoroscopic examinations without noting on the record the patient's statement as to when he was last exposed. If the patient is a "traveler," he may be burned through multiple exposures.

5. In fracture cases take a roentgenogram routinely on the day the patient is released. Besides providing you with the opportunity to explain functional versus anatomic results, you have evidence to prove the condition of the patient when released. Then if the patient has a subsequent accident, he cannot substantiate a claim of nonunion when released.

6. If your patient does not accede to roentgenography you have advised, or desires to leave the hospital before you think it wise, protect yourself against what might happen by reducing your advice to writing and handing a copy to the patient in the presence of at least one and preferably two witnesses. A written statement, signed by the patient in the presence of witnesses, refusing permission for use of roentgenography by you, or further hospitalization, is preferable. Following such procedure is of immeasurable value in event of future litigation.

7. It seems hardly necessary to state that in full records lies your greatest protection. Such records, made at the time, are the best evidence in court of conditions you found and treatment you advised. If your patient is not following your advice, be sure to make note of that at the time.

8. The importance of obtaining consent in all procedures involving operations or autopsies must never be overlooked. Neither good faith, patient welfare, nor good medical practices will stand alone as a defense against failure to secure consent, except only in those cases where an emergency makes it impractical for a physician to confer with the patient, or his guardian. See: Throne v. Wandell, 176 Wis. 97.

Burden that of surgeon.—While it is probably routine in all well regulated hospitals to secure a written consent from a patient about to undergo an operation, it must not be understood as any the less the surgeon's responsibility. And while oral consent is sufficient, difficulty of proof as to the fact that it was given condemns this procedure as insufficient protection.

Extent of consent.—A physician authorized to perform a specific operation acts at his peril in performing another or different one; nor, apparently, is he authorized to perform a more extensive and involved operation than that authorized. In all cases the consent should be sufficiently broad to include any procedures whether anticipated or not which may confront the surgeon at the time of operation. Consent must be obtained without fraud, and thus it is the safer policy to explain that sometimes unanticipated conditions or complications arise, so that, for the patient's welfare, the physician should be authorized to deal with them as they may arise.

Who may give consent.—Under ordinary conditions, and except in the emergency case as noted elsewhere, the person operated upon, if not a minor nor incompetent, may give his consent for any lawful operation. In the case of minors and incompetents, only those in the position of legal guardians are empowered to give such consent. The mere fact that a relative such as a brother endeavors to authorize an operation is insufficient, unless legal authority to do so exists.

Autopsy.—Consent is of equal importance where an autopsy is to be performed, and if it is desired to remove organs or specimens, the consent should so provide. The Wisconsin Supreme Court, in the case of Koerber v. Patek, 123 Wis. 453, held that—

> We can imagine no clearer or dearer right in the gamut of civil liberty and security than to bury our dead in peace and unobstructed; none more sacred to the individual, nor more important of preservation and protection from the point of view of public welfare and decency; certainly none where the law need less hesitate to impose upon a wilful violator responsibility for the uttermost consequences of his act. We recognize, of course, that public welfare may and does require governmental control in many respects for protection of life and health of the people, and for discovery of crime connected with the death of a person, and to such interests the private right is subservient so far as necessary. Upon this ground rest cases of autopsies upon dead bodies under public authority, and to satisfy police regulations for ascertainment of cause of death.

Dr. W. C. Woodward, for many years director of the Bureau of Legal Medicine and Legislation of the American Medical Association, has pointed out that, subject to the legal rights of coroners, the right to control and custody of a dead body vests primarily in the surviving spouse, if there is any, and if not, in the next of kin in order of their consanguinity.

In the Koerber case, cited above, the Wisconsin Supreme Court also held that—

> In absence of any surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented. Suffice it to say that the duty and right of the parent toward the body of a minor child dying a member of his household, or of the adult child toward a widowed parent, either a member of the child's family circle, or not a member of any other, seems too clear to warrant discussion.

And while Wisconsin has not yet stated any further rules, Doctor Woodward suggests that as a practical matter: "Generally it will be found that some one of a given group will be at the place of death and will assume charge of the body, and it is to such a one that application will generally be made for permission to perform an autopsy. Almost universally, such consent is recognized as valid by other members of the group; but even if it should not be, the dissenting members would have difficulty in proving they had suffered damage by any supposed trespass on their rights."

However, it is only prudent to suggest that where there is doubt, great care should be exercised, and the advice of a local attorney sought. Even where the autopsy is performed at the request of a coroner, the physician is protected only when the coroner properly has jurisdiction of the body. Generally speaking, that means in Wisconsin either that the coroner must have ordered an inquest—on his own motion or at the request of the district attorney because there is good reason to believe that murder or manslaughter has been committed—before asking the doctor to perform the autopsy, or that a cremation of the body is planned and in the coroner's judgment an autopsy is warranted. When the physician is in any doubt as to the coroner's authority to authorize an autopsy, he would do well to check first with the district attorney and then with his own attorney on the question of the coroner's proper jurisdiction.

Character of suit.—Physicians generally understand that under the Wisconsin law, if a malpractice suit is not begun within two years after the happening of the event upon which the cause of action arose, proper notice must be given. The Wisconsin court has held that this is true whether the action be one in behalf of a minor, and whether based on breach of contract or negligence. But it is not clear whether the same law applies in the case of autopsies without consent. An action involving an unauthorized autopsy may be predicated differently, and not come within the statutory contemplation of an action arising out of a personal injury.

Other examinations; treatments.—It must be pointed out that many statutes come into play in connection with specific matters of examination and treatment. With these the physician is generally well acquainted. For example, authorization for treatment may be secured from the employer in workmen's compensation cases, but this does not release the patient's right to control, even though at some possible cost to himself, the question whether he shall or shall not receive some particular treatment. Yet even this may not be the right of the patient with venereal disease. The law becomes more complex, not more simplified, with the extension of legislative programs affecting the public security and welfare; but in all this the physician must keep in mind the general rules that govern the patient's welfare and his personal relationship to him.

For a more detailed treatment of the problem of consent to autopsies see the article entitled "Coroners and Autopsies," page 82.

9. If your operative reports are typed, read them carefully and sign your name in full. Do not just initial typed records. Never sign hospital operative records in blank to accommodate the hospital.

10. In the delegation of certain duties or functions to a technician, care should be exercised that such functions are those which may be called mechanical or ministerial and require the exercise of no judgment or discretion by the technician properly that of the physician.

The Case of Threat

Assuming that some day you are given a summons in a suit, or a suit is threatened, these pointers may be helpful:

1. Report the suit or threat to your insurance company *at once.*

2. You may be invited to call on the patient's attorney to "avoid" a suit. Let your attorney do that for you.

3. Tell your own attorney all the facts even though some do not reflect credit on your judgment. He cannot help you if you "hold out" on him.

4. Do not be offended if a friend of yours is going to testify for the plaintiff. Better a friend who will give you a square deal than a quack whose testimony is purchasable.

5. Be careful of too positive statements. Tell what you know in terms the jury can understand and admit that you do not know everything in medicine. When the plaintiff's attorney gets you to making one wholly positive statement after another he is soon apt to discredit your entire testimony by showing that authorities do not agree with some two or three statements and q. e. d.—you are "all wrong."

Legal Aspects of Abortions and Miscarriages

THE two sections of the Wisconsin statutes which deal with the offenses of causing an abortion under illegal circumstances, or of causing a miscarriage were amended by the 1947 legislature so as to impose more stringent penalties for violations. Both offenses are now felonies, and because of their importance the amended statutes are quoted in full:

Abortion Statutes

"340.095 Any person who shall administer to any woman pregnant with a child any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, *unless the same shall have been necessary to preserve the life of such mother or shall have been advised by 2 physicians to be necessary for such purpose,* shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of murder in the third degree. *In case the death of the mother is thereby produced it is unnecessary to prove that the fetus was alive when the act so causing her death was committed.*" (Emphasis added.)

Miscarriage Statutes

"351.22 Any person who shall administer to any pregnant woman, or prescribe for such woman, or advise or procure any such woman to take any medicine, drug or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman shall be fined not less than $1,000 nor more than $5,000 or imprisoned in the state prison not less than one year nor more than 3 years, or both."

It should be carefully noted that the latter section relating to miscarriages, does not contain an express exception to protect the physician in necessitous cases as is the case in the abortion statute. Thus there appears to be no statutory sanction for a necessitous miscarriage, regardless of circumstances.

Court Ruling

The Wisconsin Supreme Court attempted to distinguish a miscarriage from an abortion in the case of *Foster v. State,* 182 Wis. 298, holding it evident that the legislature intended to define different offenses in the two sections. The court held that the *abortion statute* required the existence of a *living child* and the causing of its death, or that of the mother, before the offense of abortion is committed. If pregnancy has not advanced sufficiently so that there is a living child, by which is ordinarily meant a fetus at least three months old, then destruction of the fetus constitutes a *criminal miscarriage* only.

Necessitous Operations

The abortion statute above quoted exempts two types of necessitous abortions, the first of which "shall have been necessary to preserve the life of such mother," and the second of which "shall have been advised by 2 physicians to be necessary for such purpose." A physician proceeding on his own decision only that an abortion is necessary acts at his own peril. In the case of *Hatchard v. State,* 79 Wis. 361, the Wisconsin court stated: "Although he may have believed that such necessity existed, yet if in fact it did not exist, he is not exonerated. This is the plain reading of the statute."

If the operation is advised by 2 physicians other than the one performing the abortion as necessary to preserve the life of the mother, it would seem to be a complete defense. In all such cases physicians are advised to proceed only when such advice, in the form of written statements, is furnished for inclusion with the patient's record.

After-Treatment

The position of the physician called to treat a patient suffering from the results of an attempted or completed abortion is a difficult one, and may be precarious as well. Not infrequently the abortionist merely starts the procedure, advising the woman to consult her own physician for all future care. It may sometimes be difficult for the physician to identify criminally-induced cases, as distinguished from cases with natural causes, since most women are hesitant to make such an admission. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

Physician Consultant; Statement by Patients

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that procedure used in the course of treatment was itself the activating cause of the abortion or miscarriage.

In an emergency case, when no other physician is available, it is proper to insist that the patient sign a written statement, in the presence of witnesses, if possible, reciting the facts concerning the

performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after an understanding that the physican may use the statement in event he later requires it for his protection. In every instance complete, detailed patient records should be maintained.

In *State v. Law,* 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

Necessity of Reporting Case

The Wisconsin legislature, in its 1947 session, enacted Section 366.20 of the Wisconsin Statutes which requires in part that *all* physicians immediately report to the sheriff, police officer, or coroner of the county within which occurs a death following an abortion, when such a death is within a physician's knowledge. Noncompliance is a misdemeanor, punishable by fine or imprisonment. Although there has been no judicial interpretation of this new requirement, it is the opinion of legal counsel that it is intended to apply *only* to those situations in which the mother dies following an abortion and not to the destruction of a fetus.

The prudent physician will adopt safeguards over and above the statutory requirements in such cases. When consulted by a woman who has been treated by an abortionist, the physician should try to insist upon a complete disclosure by the patient to proper authorities, although this is frequently difficult if not impossible to accomplish. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death.

What should the physician do under such circumstances? Primarily, his duty is to his patient, and he should do the best he can for her up to the time it seems probable that she will die as a result of a criminal abortion or miscarriage. At that stage, it would seem advisable to afford the district attorney a chance to obtain a statement from the patient. No harm can come from such a procedure, for if the patient dies, the physician is bound to report the cause of death, and then he must either disclose the fact on the death certificate that the patient died of an artificially-produced abortion, or he must accept the responsibility for being an accessory-after-the-fact by concealing the cause of death. If the patient dies, and it becomes known either through the physician's death certificate or otherwise that a criminal abortion is suspected, the part the physician played in the case will become a matter of public notoriety in connection with any inquest that may be held, and the physician's reputation will be subjected to suspicion at the least. People will wonder what motive he had for failing to give the prosecuting attorney the opportunity of obtaining a dying declaration.

Sterilization

IN 1932, and again in 1938, opinions from the office of the attorney general of Wisconsin indicated the belief of that office that sterilization operations, except in the course of strictly therapeutic surgery, would be held illegal by the Wisconsin courts. Because of the importance of those opinions, they are printed here in summary.

1932 Opinion

The first of the two opinions was rendered by Deputy Attorney General Fred M. Wylie in 1932 in 21 Atty. Gen. 940:

"You ask opinion upon the following:

We have advised the county judge and the county children's welfare board that section 46.12 does not prohibit a sane person over twenty-one years of age from being sterilized, if he or she so wishes. We find no other section in the statute pertaining to sterilization. Please advise if our opinion was correct. Is a doctor protected in sterilizing persons who appear there voluntarily?

Is it possible for a county to pay for sterilizing indigents who are now receiving county aid and who voluntarily offer themselves for sterilization?

"Offhand, it is likely to appear that a competent adult may legally consent to be sterilized, not merely as a curative or preventive therapeutic, but solely to prevent procreation. I do not say that he or she may not, but there is sufficient contraindication in the law and in the disclosed attitude of some judges, to cause one to advise physicians that it is unwise for them to perform such an operation for sterilization purposes alone.

"Sterilization has not been received by the courts with any open-armed welcome. Against the opposition of those of the public and on the courts who consider such interference with nature to be immoral or sinful, legislatures have so far made no great strides, and a great deal of what has gotten past the opposition in legislatures has succumbed in courts.

"Even if we assume that the scientific and sociological view should prevail, nevertheless the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of sciences only when they have been accepted by the people generally. Science may have a duty to educate the law, but it has no duty to defy it, nor to take a

serious chance with it. The consequences to a physician from the performance of an operation of this kind, should the courts hold it illegal, could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilizing operation except within the ancient field of surgery, viz., when it is a therapeutic measure.

"And if the poor relief officials should, as you suggest in your letter, become parties to the performance of such an operation, they, as well as the physician, would be liable to the penalties of the criminal law in case the courts should follow the letter of the old common law and hold that change in the application thereof can be only by legislative action.

"It is not my intention in this opinion to take any position upon the religious and sociological phase of the question. It is my personal and official opinion, however, that the legal question is better to be settled in the legislature than in the courts with some well-intentioned public official or physician as the potential victim."

1938 Opinion

The second opinion was written by Assistant Attorney General Warren H. Resh in 1938, and is printed in 27 Atty. Gen. 416.

We quote the following excerpts:

"You ask whether a vasectomy 'can be performed safely' where the patient is willing to consent in writing and where it is the opinion of several examining physicians that the operation would benefit the patient's health. The man is not confined in an institution as a criminal, insane, feeble-minded or epileptic person and therefore sec. 46.12, Stats., relating to sterilization does not apply. No doubt you have in mind the mayhem statute, sec. 340.35, and the question is whether this statute would forbid sterilization in the present circumstances.

"The only case involving voluntary sterilization which has come to our attention is Christensen v. Thornby, (Minn.) 255 N. W. 620, a case notable in that the plaintiff sued on a theory of breach of warranty in that the operation did not have the desired effect, and he sought to measure his damages by the expense of a subsequent and unexpected childbirth. The court held that the contract was not void as against public policy, since it was thought to be necessary to save the life of the plaintiff's wife.

"In this regard necessity to save life and necessity to preserve health should stand on an equal footing, because of the difficulty of telling in some cases where one stops and the other begins. It is only because justified by the necessity to preserve health that a dentist who pulls an ailing incisor does not commit mayhem under the broad terms of the statute. Likewise with the physician.

"We conclude that vasectomy in the instant case may be excusable by reason of necessity to preserve health. For a more complete discussion of the subject we refer you to Miller and Dean's article in 16 Am. Bar Ass'n Journal 158 (1930). See also XXI Op. Atty. Gen. 940."

Conclusions

The following conclusions seem warranted from the only official pronouncements to date on the legal status of sterilization in this state:

1. Sterilization of individuals thus far is viewed conservatively by the courts, and will likely be strictly limited in Wisconsin to those classes of cases in which the operation is authorized by statute, namely, the institutionalized criminal, insane, feebleminded, or epileptic.

2. A physician who sterilizes an individual for any but definitely therapeutic reasons runs the risk that he is performing an illegal operation.

3. The illegal character of any but a therapeutic sterilization would not be changed because the patient or his representative consents in writing to the operation, or even requests it.

HOSPITAL CONSTRUCTION PROGRAM

For five years beginning with 1948, federal funds in the amount of $1,622,400 annually will be available to Wisconsin communities for hospital construction.

The federal funds must be matched by local funds in the ratio of two local dollars for each federal dollar allotted. The federal plan also governs the type of facilities that can qualify, including general, mental, tuberculosis, and chronic disease hospitals, and a fifth type consisting of health centers.

About 40 per cent of the federal funds available to Wisconsin are earmarked for facilities other than general hospitals.

A hospital advisory committee, appointed by the State Board of Health and headed by Dr. Harold M. Coon, superintendent of the State of Wisconsin General Hospital, formulated a state plan which has the approval of the State Board of Health and the U. S. Public Health Service.

This plan includes a priority list of communities throughout the state which will be followed in the construction of general hospitals. Priority was based on due consideration of needs and other qualifications set up in the federal plan.

The State Board of Health is empowered to administer the Wisconsin Hospital Survey and Construction Act enacted by the Legislature in June 1947.

Legal Status of Internes, Externes, and Residents

BEFORE discussing the legal status of internes, externes, and residents, it is first necessary to consider the definition of the terms, as used in Wisconsin. Little help in answering this question can be gained from the Medical Licensure Act, Chapter 147, Wisconsin Stats., 1947. The Act makes no mention whatsoever of externes or residents and only briefly refers to internes. The term "interne" is generally understood to apply to one who is engaged in a twelve-months' period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Section 147.15 makes it a prerequisite for granting of a license to practice medicine and surgery or osteopathy and surgery. The term, however, is sometimes loosely applied to the second and third year following the completion of the required period of interneship, during which similar studies are continued. *But after the first year, unless his medical school requires a longer interneship as a condition of graduation, the interne must be licensed and have the legal status of a practicing physician.* The practical effect of the statutes is to recognize, as within a proper educational sphere, a requirement that a medical student must undertake an interneship as a condition of graduation, but at the moment that the educational requirement of interneship is satisfied the individual is thereupon subject to all the licensure provisions of the Wisconsin statutes. In this discussion then, "interne" will be limited to those in the first year of interneship.

The term "externe" is professionally applied to those advanced medical students *who have not as yet reached the interne stage, or been licensed to practice medicine,* but who are performing certain assisting and observing functions, either during a vacation period or during their fourth year of medical study, under the supervision of a licensed physician. Externes enter into this course of training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

The term "resident" is generally applied to postgraduate medical students who have completed their required year of interneship and are doing what really amounts to advanced interneship work.

It is apparent then, that neither externes nor internes have the full legal status of licensed practitioners. Accordingly, the scope of their functions is correspondingly more confined. Their legal status has never been specifically passed upon by the courts, nor has the legislature seen fit to define their powers and duties, the matter being left entirely in the hands of the medical profession.

That an interne has certain functions of a medical nature which he is permitted to perform is recognized by the Wisconsin Supreme Court, in the case of *Nickley v. Eisenberg,* 206 Wis. 265. The court there admitted that internes are not subject to the medical practice act, because the Wisconsin statutes require an interneship as a part of one's medical education prior to licensure. The court summarized the legal status of an interne in Wisconsin as follows: "This is a legal sanction of the performance of such duties on the part of internes as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine or a representation that the interne is authorized to practice medicine." In the same opinion, the court recognized the legal status of certain nurses who were not registered under Chapter 149. By the same reasoning, externes would probably have a recognized status in the medical profession. But their status is such that neither internes nor externes are within the provisions of the so-called "Medical privilege statute" under the case of *Borosich v. Metropolitan Life Insurance Company,* 191 Wis. 239.

The further question arises as to those responsible for mistakes made by internes or externes while performing their customary duties. That they are personally responsible for their negligence, is, of course, conceded, and this liability may extend to physicians under whom they are working or to the hospital employing them. The law generally holds the interne to be an employe or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the workmen's compensation act, which extends employe protection to internes injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of internes in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employes or servants. See Schumacher v. Evangelical Deaconess Society, 218 Wis. 169; and Kuglich v. Fowle, 185 Wis. 124. However, where the interne is acting under the direct supervision of a physician or surgeon during the course of an operation, the hospital is absolved from responsibility and his acts become those of the surgeon or physician who has charge of the work.

An externe, as was pointed out, is generally an assistant of a physician and has no relationship to

the hospital. Because the duties delegated to an externe by a physician are generally very much limited, extending only to observation, a situation would seldom arise in which an act of an externe might cause injury. A physician would presumably have the duty to see to it that the externe be delegated no duty which would call for discretion or judgment on his part, but should he be negligent, the responsibility for his acts would doubtless be that of the physician.

A "resident" in an institution or hospital, is required to hold a license to practice medicine, 26 Opinions Atty. Gen. 504, and is as fully responsible for his acts or omissions as any other practitioner.

Reciprocity Licensure Rules

THE following are so much of the rules adopted in January, 1945, by the Wisconsin State Board of Medical Examiners, as relate to applicants for license to practice medicine and surgery without examination and by reciprocity.

Rule 1. The applicant for license to practice medicine and surgery in this state without examination and by reciprocity shall furnish to this Board as a part of his application the statement of the examining board of the state in which he was licensed listing the professional subjects in which he was examined by such Board and the grade received by him in each subject.

Rule 2. Such applicant shall also present a certificate of registration in the basic sciences issued to him by the Wisconsin State Board of Examiners in the Basic Sciences, and satisfactory evidence of having completed a premedical education, including college courses in physics, chemistry, biology, and either German or French, the equivalent of the premedical course at the University of Wisconsin.

Rule 3. If the professional college from which the applicant is graduated does not require for graduation a hospital interneship of at least twelve months in addition to a four year course, such applicant shall also present satisfactory evidence of completion of such interneship in a reputable hospital.

Rule 4. Such applicant shall also present satisfactory evidence of one year of active practice; provided, however, that a year of residency or a second year of interneship, performed in a state other than Wisconsin, shall be accepted in lieu of such one year of active practice.

Rule 5. Such applicant shall also appear personally before the Board and submit to oral examination in which he must receive an average grade of 75.

Rule 6. Such applicant shall also present satisfactory evidence of good moral and professional character.

Rule 7. This Board approves and recognizes as reputable professional colleges under section 147.17 of the revised Statutes of this state, the medical schools recognized and approved by the Council on Medical Education and Hospitals of the American Medical Association at the time of the graduation of the applicant therefrom.

Rule 8. This Board approves and recognizes as reputable hospitals for interneship under section 147.17 of the revised Statutes of this state, the hospitals recognized and approved for interneships by the Council on Medical Education and Hospitals of the American Medical Association at the time of the applicant's interneship therein.

Rule 9. The fee to be paid by the applicant for license to practice medicine and surgery without examination shall in all cases be not less than the reciprocity fee of the state whose license the applicant presents, and in no case less than $50.

Rule 10. An honorably discharged surgeon of the Army or Navy or the federal health service may be licensed without written examination upon filing of a sworn and authenticated copy of his discharge and compliance with the other provisions of this section.

Rule 11. The provisions of this section, with reference to hospital interneship and premedical education, shall not be applied retroactively so as to bar an applicant who graduated prior to the adoption of these requirements.

Rule 12. The application for license to practice medicine and surgery without examination and by reciprocity shall be in the form prescribed and on blanks provided by the Board.

In June, 1946, the Board by resolution amended the above Rules to provide that graduates of Canadian schools which are approved by the Council on Medical Education and Hospitals of the American Medical Association be admitted to licensure in this state by examination only, unless the applicant has previously been licensed by examination in a state with which Wisconsin enjoys reciprocity, or unless the applicant is an honorably discharged surgeon of the Army or Navy or of the Federal Public Health Service of the United States.

Application blanks can be secured from Dr. C. A. Dawson, Secretary, Wisconsin State Board of Medical Examiners, River Falls, Wisconsin.

Physicians and the Workmen's Compensation Act*

The 1947 legislature liberalized the Workmen's Compensation Act in a number of respects. Because these changes do not affect the professional relationship of panel physicians and beneficiaries under the act, or modify either the method of making medical reports or of computing disability, they are not added to the article.

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

As has been pointed out previously, many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission and incorporated in it are the thoughts and suggestions of its staff members.

The panel system. Prior to the legislative session of 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. The panel must be furnished even though in some instances the only physicians available are not members of the State Medical Society of Wisconsin. The Society, in cooperation with associations representing both stock and mutual insurance companies writing compensation insurance in the State of Wisconsin, undertook to enlarge the panels through the voluntary cooperation of employers and insurance carriers, in an effort to give the workmen of this state an opportunity to secure virtual free choice of attendant. Through this cooperative effort approximately 80 per cent of the workmen of this state, subject to the compensation act, thus have available to them virtual free choice of physician.

In the 1939 legislative session, the statutory limitation as to the required size of the panel was repealed, and the Industrial Commission was given the authority to determine the proper size of the panel through general orders or special orders applicable to given communities. But this amendment does not affect the agreement executed between the State Medical Society and the insurance carriers, under which a conference committee composed of both physicians and insurance company representatives was established. While the committee's responsibilities are manifold, it is important to the physicians who are members of this society that they may avail themselves of the services of that committee as an arbitration medium.

It is contemplated that the committee will function so as to reduce the differences that may arise between the insurance companies and the physician relating to the method of treatment of an injured workman, the charges made by the physician, and similar questions. Conversely, the insurance companies have the opportunity of referring to the conference committee for arbitration situations in which insurance company officials may be of the opinion that the physician's charges have been excessive or in which the physician has neglected to supply the company with the information to which it is properly entitled.

No formality is required in the cases where either the physician or the insurance companies may have a matter to report relative to the handling or disposition of compensation cases. The secretary of the State Medical Society should be informed of the general nature of the complaint and further information, if necessary, will be acquired that the committee may function to the best advantage possible.

While the committee does not meet regularly, its meetings are comparatively frequent, and questions of policy and of the application of the workmen's compensation act are being continually referred to it.

Under the law, of course, the employer is required to post the panel physicians available for treatment just as it is primarily his duty rather than that of his insurer, if he has one, to provide medical care. If the employer fails to do this, the effect of certain supreme court opinions is to hold that the injured workman has absolute free choice of physician. The medical panels of those employers whose insurance is carried by insurance companies participating in the open panel agreement with the State Medical Society are made up only periodically,

* Reprint (with some corrections and alterations) of pamphlet issued by State Medical Society, June 15, 1940, to its membership. For much of the material the State Medical Society is indebted to Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

and so far it has not been necessary to revise these oftener than once each year. A physician who desires to participate in panel listing and who is not now listed may apply to the Society. In applying to the Society, the physician agrees that if he is listed on the panel and engages in treating compensation cases, he will call a consulting physician into the case upon request of the insurance carrier. [It is expected that the physician will communicate with the insurance carrier as to the choice of consultant.]

The members of the State Medical Society should keep in mind that the effort of their Society and the insurance carriers is to provide physicians able and willing to treat compensation cases and to assure to those workmen entitled to the benefits of the act what amounts to a free choice of attendant.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because it is in the nature of a liability, those concerned with the compensation act, while they are liberal in its construction, must find three essential elements to exist in order to justify an award to the injured claimant: (1) employer-employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment. With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury. . ."

Collection of physician's account. It is important to keep in mind that there may be one of two, or two, sources from which the physician may be paid for his services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, then the employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, then the physician must look to the injured employe for payment, except ordinarily he can expect the Industrial Commission to determine the amount thereof for which the employer is responsible. Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness but may, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician-patient relationship maintained. Generally, of course, communications to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege as any physician, having attended an injured employe who files a claim under the workmen's compensation act, may be required to testify before the commission when it so directs. With reference to this the commission says: "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently, of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however, (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company, and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is controverted by the employer or insurance company either as to causative factor or as to extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a care-

ful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The State Medical Society has received many inquiries raising the question of how the expert witness is paid and to what extent. Before discussing this question in its many implications, certain basic concepts of the workmen's compensation act must be kept in mind. Of primary consideration the claimant must first establish: (1) the employer-employe relationship with both employer and employe subject to the act, and (2) the fact of an injury or disease sustained or acquired by the claimant in the course of such employment.

Second, as stated elsewhere in this memorandum, the employe is entitled, in event of injury and an award therefor, only to recompense for the injury and for the cost of treatment. The award may not be frivolous or capricious and is governed by the strict formula provided in the act itself. The award, or the jurisdiction to grant one, does not involve the unlimited field of a personal injury action but is strictly governed by statutory limitations.

In the third place, it is conceived as the function and responsibility of the Industrial Commission to protect the injured claimant in every proper way. For example, the law does not provide that applicants must be represented by attorney in hearings before the commission, but that they may appear in person or by agent or attorney. When they appear without attorney, the commission undertakes to do everything possible to assure a fair and impartial hearing. By statute, furthermore, the commission has authority to determine the reasonableness of attorneys' fees rendered by attorneys representing the claimant. By express provision of law, it is illegal for an attorney to charge in any case more than 10 per cent of the award on a contingent basis or a maximum of $100, unless the commission has first authorized such a charge. The commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the commission directs attention to the case of Philler v. Waukesha County, 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees.

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the commission as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

> "Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:
>
> | | |
> |---|---|
> | Minor examination and report, not to exceed | $ 5.00 |
> | Major examination and report, not to exceed | 10.00 |
> | X-rays where necessary to foregoing examination and report, not to exceed an additional | 5.00 |
> | Attendance at hearings on request of Commission: | |
> | for first hour | 10.00 |
> | for each additional hour | 5.00 |
>
> Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician.

In the case of state employes who file compensation claims, the commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charge:

> (Rule 18)
>
> "No claim for compensation or medical aid by an employe of the state will be allowed until the following reports and statements have been furnished to the Commission:
>
> "(2) A sworn statement by the injured employe to the effect that he was injured in the

course of his employment and reciting the time and place of the injury, the reasons for its occurrence, and the nature of the injury, and also setting forth *in detail* the expenditures incurred for necessary medical, surgical and hospital treatment and medicines, (if these bills were paid by the injured, receipts must be attached) . . .

* * *

"(4) A sworn statement from the physician and the hospital itemizing the service rendered and the charges therefor . . .

* * *

"(5) A letter from the employing department, stating its recommendations upon . . . (b) the necessity for the medical, surgical and hospital treatment, (c) the reasonableness of the bills incurred for such treatment and for medicines; . . ."

Physicians should submit their reports promptly to the commission. Delay may mean the withholding of compensation to the injured employe and of professional fees to the physician.

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating of Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.54, 102.55, 102.555, and 102.565, is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., nonschedule and schedule injuries.

Nonschedule injuries. Nonschedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts. Generally speaking, nonschedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of nonschedule injuries permanent disability is based upon wage loss consisting of such percentage of the average weekly earnings of the injured employe computed according to the provisions of the compensation act "as shall fairly represent the proportionate extent of the impairment of the injured's earning capacity in the employment in which he was working at the time of the injury, and other suitable employments, the same to be fixed as of the time of the injury, but to be determined in view of the nature and extent of the injury." (Sec. 102.11(3) Stats.) If the disability is such as to render the employe unable to perform substantially all the material duties of his own occupation, or of any other remunerative occupation which his age, training, experience, education and physical condition would fit him for, except for his disabling infirmity, his disability is total. The Wisconsin Supreme Court has held that a man's wage earning capacity is to be distinguished from his capacity to make money in a business conducted under his supervision or direction, and with the use of investment of other capital than that which arises from his own labor. The question thus resolves itself into one of employability, using care to distinguish the nonemployability resulting from the employe's physical condition from that which results because of economic conditions or other circumstances which might limit employability regardless of the employe's physical condition. In the case of one who is fitted to perform labor only, a back injury of a certain severity may cause considerable wage loss, while in the case of one suited for clerical work the same physical disability, in terms of wage loss, would be much less serious. The limitation in capability to work within a limited field of employment must be considered in determining the percentage of impairment of earning capacity. With such double limitation the probability of wage being earned by the employe is obviously more largely curtailed, and probable wage loss is greater.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to

perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been *amputated* at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the commission has found it possible to establish by custom or rule the related disability applicable to a given handicap. After many hearings with physicians, and in cooperation with the State Medical Society, the commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%
Total ankylosis of arm at elbow at right angles	
a. With radio-ulnar motion intact	50%
b. With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10% =	1%	10% =	2%
	20% =	2%	20% =	4%
	30% =	3%	30% =	6%
	40% =	5%	40% =	8%
	50% =	10%	50% =	15%
	60% =	15%	60% =	20%
	70% =	20%	70% =	30%
	80% =	25%	80% =	40%
			100% =	60%

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Middle joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	10%
	40% =	25%	40% =	15%
	50% =	40%	50% =	30%
	60% =	50%	60% =	50%
	70% =	60%	70% =	70%
	80% =	70%	80% =	90%
			100% =	100%
Proximal joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	15%
	40% =	20%	40% =	20%
	50% =	25%	50% =	25%
	60% =	30%	60% =	40%
	70% =	35%	70% =	75%
	80% =	40%	80% =	85%
			90% =	100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position ---------- 50%

Shortening of leg (no posterior or lateral angulation, age 50 or less)

1 inch ---------- 7%
1½ inches ---------- 14%
2 inches ---------- 22%

(The percentages compare loss of the leg at the hip.)

Knee

Ankylosis at 170° ---------- 40%
Limitation of motion, remaining range 135°–180° ---------- 20%

Ankle

Ankylosis—favorable position 10 to 15 degrees equinus without loss of inversion and eversion ---------- 30%

Ankylosis—favorable position with loss of inversion and eversion ---------- 40%

Loss of inversion and eversion with full dorsi and plantar flexion remaining ------ 15%

Report form. For use in reporting disabilities under the compensation act, the commission has adopted forms for use of physicians.

In order to enable the commission to pass upon disability, it becomes necessary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to the regular form, the commission has adopted another form of physician's report under the new provision of Sec. 102.17 (1) (as), effective June 10, 1943, which provides that the contents of verified medical and surgical reports by physicians and surgeons licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein, subject to such rules and such limitations as the commission may prescribe.

The purpose of this provision is to make it unnecessary for the physician to appear personally in some cases, especially where the issue in dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of hearing.

In addition to these forms the commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

Forms are available upon request to the Industrial Commission.

Estimates of Disability

Obviously methods of estimating must be in accordance with the law, regardless of the personal feeling of the physician as to the correctness or justice of the law. In general, parties are probably in agreement as to the essential justice of these provisions. However, physicians may at times have some doubt in individual cases as to the equity of one or other provision, or may feel that the law is harsh or inadequate from the standpoint of either employer or employe. That feeling should never be allowed to influence the physician, either in treating or in estimating disability.

The physician who estimates disability should, under no circumstances, concern himself with the result in number of weeks or in dollars but should confine himself strictly to the medical field in estimating the disability on a functional basis. The physician should never suggest that a case should be settled on a certain basis but should confine himself to setting out his pertinent findings. It is the function of the employer and carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be

made and upon what basis. It is clear that if the physician is influenced by the amount of compensation which may be paid to the injured, his estimate will not be on a valid basis. Neither should physicians attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than one or another physician might consider to be equitable. Computation of compensation based on estimates of disability is a function for the Industrial Commission. Attempts of physicians to compute very often result in erroneous figures and thus cause confusion and misunderstanding, both on the part of the physician and the injured person.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength, of itself *does not necessarily mean 50 per cent loss of function of the limb.* All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks established by the commission, the physician must add or subtract such percentage as he believes will represent fairly the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of injured employes. Physicians have it within their power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

In this connection it should be pointed out that many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second and proximal joints. Some physicians refer to the first, second, third and fourth fingers, and some designate the thumb as the first finger. Also some physicians speak of the interphalangeal joints, and sometimes of the first, second and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reporting can be avoided.

As it is the commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the commission to check the report with the commission's standards and to arrive at an intelligent and uniform conclusion.

From time to time physicians propose certain standards or schedules for the measurement of disability. The commission wishes to call attention to the fact that no standards or schedules not adopted by the commission have the approval of the commission. Only those standards adopted and published by the commission itself should be considered as authoritative or as representing the commission's thought as to percentages of disability based on certain functional losses. It is appreciated that other schedules may be studied as a matter of interest by physicians who will undoubtedly wish to arrive at an opinion based upon their own examination and analysis and by reference to the standards which the commission has authoritatively adopted.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical detail of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission will be happy to be of assistance in the medicolegal problems confronting the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison 2, Wisconsin.

Agreement on Panel Practice

AT THE suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin, the State Medical Society of Wisconsin entered into a joint agreement with them to permit employes eligible to benefits under the workmen's compensation act to have free choice of physician. Through the medium of this agreement any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel which is certified to the insurance companies. This agreement makes it possible for from 75 to 80 per cent of the employes in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. **The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon.** It is recognized that exceptions will occur to this portion of the agreemeet, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company association is as follows:

Agreement on Panel Practice in Wisconsin

The workmen's compensation law of Wisconsin requires all employers to maintain a panel of five physicians, from which an injured employe shall have the right to make choice of an attending physician in case of accident.* In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. In order to provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representative of the State Medical Society of Wisconsin, established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

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* This provision of the original agreement is now obsolete, as the commission requires a "reasonable choice" of physicians in light of community medical resources and needs.

Medical Witnesses and Expert Testimony

Introductory

NEVER before has medical testimony assumed such importance as in recent years. Formerly many medical men asserted that they did not care to be drawn into litigation, but it is now next to impossible for an active general practitioner, much less for a specialist, to escape at least some appearances either before courts or such administrative tribunals as the industrial commission. Medical testimony is important and frequently even of controlling weight in cases involving mental competence as, for example, lunacy, guardianship, and will proceedings. It is also of paramount importance in the field of industrial accidents and disease, while the increased use of the automobile has in itself given rise to an almost independent branch of jurisprudence and with it problems of forensic medicine.

The subject falls logically into two divisions. The first is that of the ordinary nonexpert medical witness, and the second is that of expert or opinion testimony ordinarily offered only by specialists. A number of observations may be made with equal applicability to both classes of medical witnesses.

Duty to Testify

One of the first questions which arises in the mind of the physician is his duty with respect to offering testimony either in a nonexpert or expert capacity before a court or administrative tribunal. It may seem an elaboration of the obvious to recall that the physician is first of all a citizen and as such an integral part of his community; that the courts, and such bodies as an industrial commission "are part of the machinery of his government." The average physician undoubtedly has a professional duty to assist with his training and knowledge, a judge or public administrator who may have need of his judgment. This is quite apart from any legal requirement.

On the purely legal side it is well settled in Wisconsin, as elsewhere, that a doctor must obey the order of a court or other properly authorized public official to appear and offer testimony in a given case. This order customarily takes the form of a subpoena and the doctor must obey a subpoena, just as any other citizen, under penalty of contempt.

Medical Privilege

Both the nonexpert and expert medical witness must remember at all times that section 325.21 of the Wisconsin Statutes makes privileged any information which the physician may have acquired in attending any patient in a professional capacity, necessary to enable him professionally to serve such patient. (See "Privileged Status of Testimony of Physicians and Surgeons in Legal Proceedings," page 80.) The only exceptions are: homicide trials, lunacy inquiries, civil or criminal malpractice actions against the physician, and express waiver of the privilege either by the patient, or in the event of the latter's death or disability, by such person's personal representative.

I. NONEXPERT TESTIMONY

General Scope

Generally speaking, the testimony of an ordinary practitioner appearing in a nonexpert capacity is much more limited in character than that of his brother physician who has qualified and is appearing as an expert. Ordinarily, the general practitioner may testify only to what he has observed in the case of a given patient and a given disease. He is limited to the facts which have come from his own professional diagnosis and observation, although even the nonexpert medical witness generally is given a latitude unknown among nonexpert witnesses in other fields, that of prognosis. This undoubtedly is judicial recognition of the high general training of the medical profession, and of the further fact that a physician is as greatly concerned with prognosis as with diagnosis and treatment. No medical witness whether nonexpert or expert should ever volunteer an answer to a question to which he does not know the answer. Neither should he fall into the trap of giving an opinion which exceeds either his training or his observation.

Preparation

While no conscientious physician will venture before any tribunal unprepared, unless summoned without notice, it may be said as a general proposition that exhaustive preliminary research either in the laboratory or in medical literature is not be expected in the case of the nonexpert witness. It is ordinarily enough that he review his case notes, hospital record or other memoranda, and limit himself to what they show, together with such other findings as are within his personal knowledge.

Neither the nonexpert nor expert medical witness may employ medical texts to supplement his testimony. It is permissible in some states to quote medical authorities who agree with the findings of the witness, or for the witness to state that his diagnosis or prognosis is supported by a certain medical writer. It is undoubtedly advisable for any physician before going into court to have in mind at least the leading literature of the particular field in which he is going to testify, unless it is so highly limited that only a specialist could be expected to know it. By having that minimum preparation he may be saved the embarrassment of seeming unfamiliar with outstanding medical literature, which admission is frequently elicited by the attorney for the other

side for the sole purpose of casting doubt on the validity of the witness' otherwise competent testimony.

Compensation

The question of the compensation of the nonexpert witness rather commonly arises, and is a matter which should be settled, wherever possible, in advance of the physician's appearance before a tribunal. As a matter of strict law neither a nonexpert nor expert witness is, merely in his capacity of witness, entitled to more than the statutory fee, which in Wisconsin is $2.50 for a court of record. If a nonexpert witness is to receive more compensation than is given him by law, this should be arranged for with the person requesting such witness' public attendance and testimony. It is reasonable for the nonexpert general practitioner to ask compensation, within the financial limits of the party on whose behalf he appears, which will roughly compensate such witness for the loss of time and inconvenience to which he is put.

Care should be observed, however, in the interests of the physician's own integrity, and in the best interests of justice, that the physician at no point acquire a monetary interest in a given piece of litigation which might even unconsciously color his judgment. While no exception can be taken to a physician's testifying as favorably as he conscientiously can for the particular side on which he is called, the ethical physician will be careful never to have a vested interest in the outcome of a pending case.

II. EXPERT TESTIMONY

General Scope

The general subject of expert or opinion testimony is the peculiar province of the expert witness. In the words of a recent author on jurisprudence: "An Expert Witness is one who has made the subject upon which he gives his opinion, a matter of particular study, practice or observation, and who has a special knowledge on the subject, which must be recognized in law as a distinct department of human knowledge and endeavor."

The Wisconsin Supreme Court, in a leading case on the subject, states: "*The more difficult field is entered when we approach the question of calling upon men of exceptional experience and qualifications to give their opinion as the result either of facts which they observe or from an hypothetical statement of facts. This is the real field of expert evidence. It is there that the expert can testify and the nonexpert cannot.*"

Meaning of "Expert"

At the outset care should be taken to distinguish two senses in which the word "expert" is commonly used. As the Wisconsin Supreme Court has wisely observed "Much of the testimony of a so-called expert is in no wise different in character from that of any other witness." Frequently both attorneys and courts seem to regard *all physicians* as expert in the general field of treatment of human illness by comparison with laymen. It is true that all physicians are expert in the sense of being peculiarly and specially educated in the general subject of medicine. The situation is further complicated by decisions holding that, although a physician is not a technical specialist in a particular branch of medical science, he may testify as an expert, where, assuming hypothetical statements of fact to be true, he can express an opinion, satisfactory to himself without further study, as to a question of science pertaining to a special field.

Perhaps the principal difference between an expert and nonexpert medical witness, is that the former's testimony is far less circumscribed. The nonexpert is limited to matters within his personal observation and knowledge. The nonexpert may not ordinarily express an opinion, as differentiated from facts, except in the field of prognosis. The expert, on the other hand, may, in addition to stating observations and other facts within his personal knowledge, give opinions based on two sources other than professional observation of the party as to whom he is offering testimony. These are: (1) Information gained by him from testimony which the expert heard in court; (2) Information assumed by a hypothetical question propounded to him.

Qualifying Physician Expert

Whereas the general practitioner is ordinarily qualified with the statement that he has been admitted to the practice of medicine in Wisconsin, and that he has practiced for a given number of years, the expert must be qualified far more carefully. He should make statements as to his postgraduate studies, his research, any writings, any teaching or other positions, any specialized experience or practice, the fact that he has had opportunity to observe an exceptionally large number of cases, or anything else designed to set him apart from the general practitioner or non-specialist. The careful qualifying of an expert witness is highly important not so much for its psychological qualities in impressing a tribunal or a jury, as because it lays the foundation for the degree of weight to be attached to the testimony subsequently offered.

When Expert Opinion Warranted

As has already been stated it is equally the duty of the expert as well as the nonexpert medical witness to respond to a properly issued summons to appear before a tribunal. This rather fundamental difference may be noted however, between the expert and nonexpert witness. The essence of the nonexpert's testimony is *facts* and *actual observation*, whereas the essence of the expert's testimony is *opinion* based upon a special skill and experience even in the absence of observation of a given case. A nonexpert witness would undoubtedly be in contempt of court for refusing to tell what he *knew* in

a given case especially where the patient has waived the statutory privilege, but a court cannot compel an expert to have an *opinion* concerning a situation of which he has not personal knowledge, or as to which he has made no observations. However, if the expert does have an opinion, whether previously familiar with the case then before the tribunal, or not, he is under legal duty to offer that opinion if so requested. The question whether a physician after being in attendance on a patient may be compelled to testify as an expert may be answered in the affirmative if such physician can qualify as a technical expert on the particular ailment or disability involved in a given case. In other words, actual observation should, if anything, lend greater strength and credibility to a medical expert's testimony than a theoretical response to a hypothetical question.

Preparation

Still another important difference between the nonexpert and expert witness lies in the amount of preparation prior to appearance before the tribunal. While the nonexpert witness will ordinarily not be expected to do more than review his case notes and tell what he has observed, and what he knows as a result of such observation, the expert cannot stop at this point. By the very reason of his being an expert he is supposed to know much better than his nonexpert fellow physician the medical literature, the laboratory aspects, and the technical medical side of the particular point in issue. This presupposes preparation of a most careful character. Wherever possible, it will presuppose examination of the patient and a personal knowledge of the history of the case. This is not always possible in the case of adverse parties, or of a deceased, and it is for this reason, among others, that opinion evidence and the hypothetical question are so commonly employed.

The Hypothetical Question

Much has been written, a good deal of it critically, of the hypothetical question which is so commonly employed in the examination of expert witnesses. Such a question has been defined as "one which states and assumes as true certain probative facts appearing in evidence, and asks the opinion of the witness thereon as to some ultimate fact in issue." Hypothetical questions should be so formulated as not to invade the fact-finding province of the jury; they need not be limited to undisputed facts, but should not contain facts which are not before the tribunal. Such questions should cover sufficient ground to justify invoking expert opinion, should be technically as accurate as possible and should never be unfair or misleading.

Hypothetical questions have frequently found disfavor both with courts and the medical profession, but they serve a perfectly legitimate function, namely that of assuming a given medical or other factual situation, thereby filling gaps in the witness' own opportunities for observation and diagnosis in a given instance. Such questions also serve as a check on the facts, and further, afford a basis for prognosis which is frequently all-important in personal injury or industrial cases.

Where it happens that an expert witness has likewise treated the patient he is competent not only to testify on the basis of what he has seen and knows of the specific case, but also to give opinion evidence and to answer hypothetical questions.

Compensation

The question of compensation very properly arises in connection with expert medical witnesses. By very reason of the fact that such witnesses are expert they customarily command higher remuneration than do general practitioners; they commonly travel a longer distance; they are expected to prepare much more fully and comprehensively than nonexperts. Skill, special knowledge, exceptional or even unique experience, all distinguish them from the ordinary medical witness. All of these marks of the expert may properly be weighed in considering what constitutes fair compensation for the testimony of such a person.

Warning cannot be too strongly sounded, however, that while an expert should have compensation which is fair under all the circumstances, he should not be given a monetary interest in the outcome of the litigation, nor should his compensation in any way depend upon the character or emphasis of his testimony. His compensation must always have professional rather than commercial limits. Whenever the facts are otherwise the result in too many cases will tend to be at least an unconscious coloring of such expert's testimony because of his almost proprietary interest in the consequences of what he says. Both legal and medical literature are replete with warnings against luring the expert witness from a professional plane and making him what is for all practical purposes almost a proponent in the litigation. An expert who so acts reflects discredit on himself, on his profession and on the entire practice of permitting the offering of opinion evidence.

Decalogue For Physician Witness

No better guide is available for the almost religious observance of both nonexpert and expert medical witnesses than the following decalogue, brought to the attention of the medical profession by Dr. A. I. Rosenberger, Milwaukee, who in turn has ascribed it to Dr. W. E. Grove, Milwaukee:

1. Examine your case thoroughly and repeatedly so that you know what you are talking about. Know your facts well. They must be incontrovertible. The opinion you form from these facts is your own, but must be arrived at honestly.

2. Testify slowly, clearly, simply, and in language that the layman can understand. Forget your Latin medical terms. You are obliged to talk down to the level of intelligence in the jury box in order to get your facts across.

3. Stick to the unvarnished truth. If you do not, your statements will strike back at you like a boomerang.

4. Do not become partisan or assume a proprietary interest in the legal proceedings, for if you do, it will diminish your value in the eyes of the court and the jury.

5. Maintain your dignity and do not advise or consult with an attorney in the courtroom, but sit far away from him. The attorney should prepare his case before he goes into court.

6. You are not required to answer by "yes" or "no" an involved question if such answer places you in the position of the man who was asked, "Have you stopped beating your wife?" Your "yes" would be a lie and your "no" a prevarication.

7. If a long, involved, hypothetical question is to be propounded to you, request that it be given to you in writing before you are put on the stand so that you may thoroughly study it and not embarrass your attorney by your answer.

8. Refuse to answer any question which puts you into some other field of medicine than your own. You may always say, "I cannot qualify."

9. Do not allow an attorney of the blustering, bull-dozing type to anger you or "get your goat." The purpose of this line of questioning is to throw you off guard.

10. Remember that at times the most valuable words in the English language are, "I do not know."

Privileged Status of Testimony of Physicians and Surgeons in Legal Proceedings

Medical Privilege Rule

THE present law relating to privilege accorded the testimony of physicians and surgeons in Wisconsin courts is as follows:

325.21 **Communications to doctors.** No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to *serve such patient*, except only (1) in trials for homicide . . . , (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition.

This statute refers only to the testimony of a physician or surgeon in legal proceedings, and is to be distinguished from subsection (d) of section 147.20 (1), Wis. Stats., which provides for revocation of the license of a physician or surgeon for wilfully betraying a professional secret. Testimony within the protection of the statute includes information given by the patient in good faith, even when the physician or surgeon could have diagnosed and prescribed without it, and may include the physical circumstances of an injury and its occurrence, or the previous condition of an injured part of the body if, in the opinion of the physician or surgeon, such information is necessary to enable him to serve the patient.

The law relating to privilege is statutory and has no basis in the common law. Accordingly, the tendency of the court is to interpret the statute strictly and literally and to enforce only such restrictions as the statute specifically imposes, and not to add restrictions which the legislature may have omitted. As a result, certain interpretations and constructions of the statute have been made which are important to know.

For a long time the Wisconsin Supreme Court has adhered to the doctrine that a physician or surgeon may testify, or may be compelled to testify, to a condition observed by him when unconnected with treatment, even when the person observed or examined for purposes other than treatment is or was a patient of the physician. Following this principle the court has held that a physician or surgeon may testify as to a death certificate made by him, or as to an autopsy performed by him. In *City of Racine vs. Woiteshek* decided by our Supreme Court on November 18, 1947, the court held that the lower court should have admitted the testimony of a physician who by examination determined for the police the extent of intoxication of a man charged with that offense. Similarly, the Attorney General has held that the information acquired by a local health officer is not privileged when he examines a person in the course of his statutory duties as such officer.

The Supreme court has held that a nurse could testify, although the doctor could not, as to a record made by her at a patient's admission and during his treatment, in spite of the fact that the record was used by the doctor in treating the patient, because the statute specifically names only physicians and surgeons. For this same reason, testimony of an interne, attendant or roentgen ray operator, or the roentgenogram made by him, is not privileged.

The privilege of the statute may be waived by the patient himself, or by his personal representatives or by beneficiaries of an insurance policy. Although it might appear from a reading of the statute that waiver by a personal representative is to be permitted only in personal injury cases, nevertheless, the court has recently held that the personal representative may waive the privilege and intro-

duce the testimony of a decedent's physician as to the health and physical condition of the decedent prior to death in a case involving a tax on gifts made in contemplation of death. Hospital records for patients in a State Hospital who are recipients of Veteran's Administration grants as dependents of ex-servicemen are not to be revealed to attorneys of the Veterans Administration or anyone else without the authority of the patient, his family, or his guardian. It makes no difference whether the physician obtaining the information is a public official or employee. Where the patient is under disability, the legally appointed guardian should give the required authority rather than the members of the patient's family. The parents may give the authority on behalf of minor children. See 35 Opinions of the Atty. Gen. 116.

Exceptions from the privilege, of course, are those facts learned by the physician in observation or treatment of a person or patient which he is by statute required to report to the proper authorities. Among these are communicable diseases, including venereal disease; cancer, carcinoma, sarcoma or other malignant growths; and occupational diseases.

Among the more common situations arising today in which the physician is asked to disclose privileged information are those in the preemployment or periodic health examination of employes, and those in which an insurance company seeks information to serve as a basis for writing a policy in favor of the patient or for adjusting a claim made by a patient who may carry health, accident or sickness care coverage. For his own protection, the physician must always obtain the signed authorization of the patient before divulging such privileged communications. Such authorization should also identify the person or organization to which such disclosure may be made, and should specify the information to be disclosed. The physician should not disclose information beyond that permitted by the authorization, for if he should go beyond the limits of the patient's waiver, he may be charged with wilful betrayal of a professional secret. Insofar as the periodic health examination or preemployment examination of employes in industry is concerned, the State Society has developed a specific form of release which appears on model examination forms, approved by the Industrial Commission. These forms are available through the State Medical Society at the cost of printing.

While it is difficult to express a general principle, a physician who is rendering a bill to poor relief authorities for professional services rendered relief patients should avoid reporting details beyond those absolutely necessary for reimbursement.

Upon making a premarital examination the physician may find that while the applicant is free from venereal disease, he does have some physical or mental disability or abnormality which would render him unfit for marriage or would make impossible the consummation of a satisfactory marriage relationship. The question then arises as to the liability of the physician upon disclosure of his findings to the other prospective spouse.

This problem is discussed in an article appearing in *The Ohio State Medical Journal* for November, 1941. Believing that the conclusions there drawn are of equal merit in Wisconsin we reprint here the conclusions both as to (1) the liability of the physician to the examiner, and (2) the liability of the physician to the state.

"A physician, disclosing to the other prospective marital partner disabilities or ailments of an examinee that would endanger the other party to the prospective marriage or that it would make it impossible for the parties to enjoy a happy or satisfactory marriage relationship, is subject to no liability to the examinee, either in libel or slander or for disclosing a professional secret within the limitations noted; that is, if he acts in good faith and without malice and makes no further disclosures than is reasonably necessary under the circumstances. Obviously, the problem is simplified if the same physician examines both parties with the definite understanding that findings and observations, if at all material to the prospective relationship, shall be made known to the other party; or if the physician acting with respect to one party only enters into a similar understanding."

"The disclosures under the circumstances here assumed would not constitute the 'wilful betrayal of a professional secret' and would not be the basis for the revocation of the physician's license."

Rule in Personal Injury Cases

In addition to the privilege statute itself, there has been since July 1, 1939, a rule promulgated by the Supreme Court which has the force of statute and reads as follows:

The court or a presiding judge thereof may, upon due notice and cause shown, in any action brought to recover for personal injuries, order the person claiming damages for such injuries to submit to a physical examination by such physician or physicians as such court or a presiding judge may order and upon such terms as may be just; and may also order such party to give to the other party or any physician named in the order, within a specified time, an inspection of such X-ray photographs as have been taken in the course of the treatment of such party for the injuries for which damages are claimed, and inspection of hospital records and other written evidence concerning the injuries claimed and the treatment thereof; and if compliance with the portion of said order directing inspection be refused, the court may exclude any of said photographs, papers and writings so refused inspection from being produced upon the trial or from being used in evidence by reference or otherwise on behalf of the party so refusing. Sec. 269.57 (2).

This rule is restricted to personal injury cases. That part which deals with a physical examination of the injured party is not inconsistent with the privilege statute because the examination is being made not for treatment but for a purpose independent thereof. As to its effect on introduction of records in a trial, it will be noticed that the order does not compel a party to permit inspection of such records and written evidence, but provides a penalty in case of refusal in that the party refusing may not himself use them or produce them in the trial.

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Coroners and Autopsies

A COMPLETE discussion of the powers and duties of the coroner would necessitate covering as well the powers and duties of the sheriff for in the event that a sheriff or his deputy, for one of several reasons, is prevented from performing the duties of that office, the responsibility becomes that of the coroner. Since only in rare instances does such a situation arise, and since such powers and duties bear little or no relation to matters pertaining to physicians, this discussion is limited to the more familiar and specific powers and duties prescribed by law.

The principal contact of the practicing physician with a coroner is in connection with the performance of autopsies requested by that officer. It should be emphasized that unless the physician has the express consent of the immediate family of a decedent, he subjects himself to the possibility of a lawsuit and the payment of damages by performing an autopsy excepting where directed to do so by a:

1. Subpoena issued by a coroner or his deputy subsequent to the ordering of an inquest.
2. Subpoena issued by a justice of the peace who has been ordered by the district attorney to conduct an inquest in the absence of a coroner.

Ordinarily a coroner, his deputy, or an authorized justice of the peace first contacts a physician to inquire whether he is available to perform an autopsy. The physician thus has notice of the intended autopsy before being served with a subpoena. The prudent course for the physician, unless he has personal knowledge of the steps taken and the summoning of an inquest jury, is to make sufficient preliminary inquiries to satisfy himself that such inquest has been ordered. Where the subpoena comes from a justice of the peace he should also check with the district attorney to make sure that the district attorney requested the justice to act in the capacity of the coroner because of the latter's absence. Only by observing such precaution will the physician protect himself against suit by the family of the decedent. See *Koerber v. Patek*, 123 Wis. 453. For fuller treatment of this liability see article on "Malpractice and Malpractice Suits," on page 61 of this issue. Where the situation contains any element of uncertainty, the physician would do well for his own protection to consult his own attorney.

Section 59.34, of the Wisconsin Statutes, provides in part that the coroner shall take inquest of the dead when required by law, and shall perform all other duties required by law.

The most important duty, of course, is that relating to inquests, the details of which are set forth in Chapter 366 of the Wisconsin Statutes. The legislature has deemed it advisable to leave with the coroner a wide range of discretion.

Section 366.01 provides that when, from the circumstances surrounding the death of any person, the district attorney shall have good reason to believe that murder or manslaughter, negligent homicide, excusable or justifiable homicide has been committed, he shall order and require the coroner or his deputy to take "an inquest as to how such person came to his death." The statute, however, also gives the coroner on his own initiative, the power to hold an inquest. The function remains substantially as it has for several centuries. The inquest must be held in the county where the trial for the offense could be held regardless of the fact that the resulting death took place in another county.

The coroner's source of information of the death of a person is, of course, varied. Everyone, including a practitioner, owes a duty to report a death to proper authorities when circumstances indicate that a homicide or manslaughter may be involved. A physician, presumably, would be in a better position to draw such conclusions than would a layman; and where the practitioner attends a death involving suspicious circumstances, he would do well to notify the coroner or the sheriff's office.

Inquests

The coroner's first duty, upon being notified of a death, in absence of any request by the District Attorney to hold an inquest, is to determine whether or not in his opinion the facts warrant or require the holding of an inquest. This duty is purely discretionary; the only limitation, presumably, being that which relates to the District Attorney, that is whether there is good reason to believe that murder or manslaughter, negligent homicide, excusable or justifiable homicide has been committed. It is impossible to lay down any rules for use in determining when good reason exists. Whether or not the coroner acts will, of course, depend on a number of facts: the objective circumstances of the case, incidental information available to the coroner, and, not to be overlooked, the coroner's own conception of the duties of his office.

Having concluded that the circumstances warrant or demand the taking of an inquest, the coroner's next step is to issue a so-called precept or order to the sheriff or constable to "summon a jury of six good and lawful men of the county to appear before him at the time and place specified in the precept." The coroner may in his discretion dispense with the summoning of a jury and conduct the inquest himself and render a verdict thereon in the same manner as a coroner's jury would do. (In this connection it is pointed out that the power to hold an inquest is an absolute one and should the body have been buried, the coroner or his deputy can compel such body to be exhumed for the purpose of complying with the provisions of

chapter 366, provided an inquest has been ordered.) The form of the order compelling the summoning of a jury is prescribed by the statutes. No time limitation is provided for setting the date of the inquest, but the desirability of prompt action in inquests is self evident, and it is the coroner's duty to see to it that prompt administration of the laws be accomplished. In addition to the order compelling the attendance of the jurors, the coroner may issue subpoenas of witnesses, included among which might be one or more competent physicians or surgeons, for the purpose of making an examination of the body and testifying as to the result of the same. Thus, in the exercise of his powers and duties the coroner is called upon to perform functions which are in their nature both judicial and medical.

Medical Functions

The most important medical duty is the investigation of deaths in which an element of violence may be suspected. These might include accidental or suicidal deaths, and deaths of persons who have not been attended by a duly licensed practitioner of medicine, when the cause of death appears uncertain. In making an investigation, the first consideration is how far it will be necessary to carry the examination, a matter which requires the exercise of care and good judgment. The coroner's questioning should be careful and searching, but having satisfied himself as to the natural cause of death, he is justified in going no further in his investigation. If, however, the death requires the discovery of facts other than those which may be revealed by questioning and inspection the coroner must be in a position to avail himself of those highly specialized medical services involved in an autopsy.

Quasi-Judicial and Other Duties

Having decided on the necessity for an inquest, the coroner's duty immediately becomes one of both an administrative and a judicial character. In Wisconsin, properly speaking, he is not a judicial officer under the state constitution. 20 Atty. Gen. 323. Nevertheless he has the power to exclude the public from inquests whenever he deems that to be desirable. He does the work of a practicing attorney in bringing out the testimony of witnesses, who are not, as a matter of right, entitled to representation by attorney. The statute provides that the jury is to find not only what caused the death, but who was responsible for it. Because of the informality of the procedure, the coroner is in a position to exercise a great influence over the jury even though the jury's findings are not admissible evidence in a subsequent court trial of an apprehended party. See Groeschner v. John Gund Brewing Co. (1921) 173 Wis. 366, at 370. Nevertheless the coroner can frequently be the primary force in bringing a criminal to justice.

Being in charge of the inquest, the coroner, of course, is not in a position either to perform an autopsy or to testify as to the cause of death. If he is a physician, however, his medical training would aid him substantially in preparing questions to be asked of the medical witnesses called. 1910 Atty. Gen. 578.

In the absence of the holding of an inquest the coroner is in no different position than an individual as far as stating the cause of death is concerned. Section 69.41 of the Wisconsin Statutes, provides, however:

69.41 Coroner's certificate. Any coroner who holds an inquest on the body of any deceased person required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall furnish such information as may be required by the state registrar to classify the death.

A further duty is imposed upon the coroner by Section 366.19, Wisconsin Statutes, which provides in subsection (2):

It shall be the duty of the respective coroners of this state, in any case where the body is to be cremated, to make a careful personal inquiry into the cause and manner of death, and conduct an autopsy or order the conducting of an autopsy, if in their opinion it is necessary to determine the cause and manner of death, and thereupon certify that no further examination or judicial inquiry concerning the same is necessary, if so satisfied, otherwise, or in the event of doubt to proceed as otherwise provided by law.

This article does not even purport to treat the situation in which the physician performs an autopsy at the request or with the consent of the decedent's immediate family. In such cases no other authorization is required from the coroner or any other public officer. See "Malpractice and Malpractice Suits," page 61.

LIQUOR PRESCRIPTIONS AND THEIR ABUSE

With the price of liquor skyrocketing, physicians are again being set upon by friends seeking ingredients for the old prohibition recipes. It is as important now to resist such entreaties as it was in the "Terrible Twenties," because of various criminal implications and possible license revocation.

The Wisconsin Statutes, for example, provide a fine or imprisonment for a physician who prescribes intoxicating liquor to any person when unnecessary in his treatment with an intent to evade the tax or license requirements established for the sale of liquor. See Sec. 176.19, Wis. Stats., 1945.

Narcotic Laws

State and Federal Statutes and Regulations

THE December, 1941, Blue Book issue of *The Wisconsin Medical Journal* contained an article written by the U. S. Commissioner of Narcotics, H. J. Anslinger, entitled "The Harrison Narcotic Act, and the Practitioner." This study which is not reprinted here is both authoritative and complete and sets forth in detail the provisions of the act and its relation to the practitioner. The Harrison Narcotic Act was technically drafted as a revenue measure, for only through the taxing power can the federal government control or regulate traffic in drugs within the states themselves, but it was primarily intended, as Justice Holmes pointed out in United States v. Jin Fuey Moy, (1916) 241 U. S. 394, to control and regulate the sale and use of narcotics.

State Law

The federal act, however, because of constitutional limitations on the scope of its operations, was not sufficient. Supplemental state legislation was essential. This need was recognized by the proposal in 1932, by the National Conference of Commissioners on Uniform State Laws, of a "Uniform Narcotic Drugs Act," and since that time, forty-one states, including Wisconsin, have adopted the act; this state having done so in 1935.

The state act was intended to facilitate the regulation, control, and enforcement, with particular emphasis on enforcement, of the use of narcotics in conformity with the aims and purposes of the federal act. In drafting the state law, effort was made to avoid any duplicate effort, either on the part of the enforcement officers or the persons subjected to the act. The state law makes specific reference to the federal act and provides that a compliance with the federal law shall constitute a compliance with corresponding sections of the state law.

Federal Law

The procedure to be followed by practitioners and others subject to the law is adequately set forth in the article by Commissioner Anslinger, which was printed in the December, 1941, issue on page 1240. From it the practitioner may obtain the general procedure required of him. Some statutory requirements and penalties relating to the physician's professional use of narcotics and marijuana are summarized for the physician's convenience at the end of this article. There are certain additional factors which merit consideration by the practitioner, some of which arose subsequent to the passage of the Wisconsin law, and which, while not specifically falling under the provisions of the federal Harrison Narcotic Act, are related to the subject in a general way.

Use of Narcotics and the Practitioner

It must be remembered, first of all, that the practitioner can use narcotics only in connection with patients upon whom he is in attendance in the regular course of his professional practice. Except for the provisions of Sec. 161.27, Wisconsin Stats., forbidding the possession and use of opium pipes and Sec. 161.275, as enacted by chapter 49 of the Laws of 1939, outlawing smoking preparations of hemp or loco weed and the use of marijuana in a form suitable for smoking or beverage purposes, neither the state nor federal act places any limitation upon the quantity that may be used, the time during which it may be continued, or the form in which it may be administered.

The courts have, however, definitely held that the administering, dispensing and prescribing of drugs for the sole purpose of satisfying the craving of an addict is not within the limits of professional practice as contemplated by the act. In the use of such drugs the practitioner must always act in good faith. Because of this construction of the act by the courts and the similar position taken by the federal authorities the practitioner should take care to avoid any suspicion of noncompliance, not so much because of possible conviction but because of the trouble, expense and adverse publicity which might result should an innocent practitioner be charged with violation of the act.

Hitherto, certain small quantities of narcotics were exempt from the provisions of the state act where prescribed, dispensed, or sold at retail. A 1941 amendment limits the exemption to preparations which do not contain an excess of 1 grain of codeine or any of its salts in one fluid or avoirdupois ounce. The preparation containing codeine must also have medical value other than that possessed by the narcotic alone. All other preparations are now in the prescription class. In consideration of the narcotic law's application, the practitioner should keep in mind the following three phases of the problem: administration, dispensation, and prescription.

1. *Narcotics Administered by Practitioners.*—It is in this branch of the use of narcotics that the practitioner is given the greatest freedom. Under the federal law, he is not compelled to keep a record of the drugs administered either by himself or by his duly authorized assistant, intern or nurse. The state law, however, does require practitioners to maintain a record of any narcotic drugs administered except—

Narcotic drugs administered, dispensed or professionally used in the treatment of any one patient, where the amount administered, dispensed or profes-

sionally used for that purpose does not exceed in any forty-eight consecutive hours, (a) four grains of opium, or (b) one-half of a grain of morphine or of any of its salts, or (c) two grains of codeine, or of any of its salts, or (d) one-fourth of a grain of heroin or of any of its salts, or (e) a quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

2. *Narcotics Dispensed by Practitioner.*—Under both acts, the practitioner is required to keep a record of all narcotic drugs dispensed by him, such record showing the amount, date dispensed, name and address of the patient; this record must be kept for two years. One record will suffice for both federal and state requirements. When the practitioner's office is accessible to the patient, the dispensing of narcotics should be avoided as much as possible; certainly no more should be placed in the hands of patients than is necessary to provide until the next visit.

Attention is called to a special rule applicable to physicians dispensing exempt narcotic preparations, such as paregoric. The rule is expressed both in the federal act and in the treasury regulations and provides that a dispensing physician, among others, must keep a record of all sales, exchanges, gifts or other disposition of such exempt preparations. The record of disposition must be made at time of delivery and must show the name and address of the patient, the name and quantity of the preparation and date of delivery. A 1942 amendment to the regulations holds this rule to be an independent requirement of law, binding on all physicians and others who dispense exempt preparations. Any violation of the rule is subject to the criminal provisions of the Harrison Narcotic Act.

3. *Prescribing by Practitioner.*—The laws do not compel the practitioner to keep records of the prescriptions issued, but the physician's case records should be complete and in detail. The practitioner should bear in mind that the best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure, and that an attempt to cure under such circumstances may furnish grounds for suspicion of violation. Both the federal and state laws contain specific reference to drug addicts, and it is only in exceptional cases, such as those of aged and infirm persons, that a practitioner is justified in furnishing an addict with the means of obtaining a supply of drugs, and then only in the course of the physician's "professional practice."

The physician must never prescribe, dispense or administer narcotics to a "transient addict" merely to satisfy such addict's narcotic requirements. If the physician determines *after* a physical examination that the addict is in need of medical treatment and that as a part of such treatment he should have narcotics in an amount which is reasonable for the particular patient, the prescription, dispensing or administration of narcotics under such circumstances is within the law.

A pharmacist may fill a narcotic prescription only upon receipt of a written prescription. Attention has been called by federal narcotic authorities to the growing practice on the part of physicians of telephoning narcotic prescriptions with the intention of later mailing or delivering them to a pharmacist for filing. Such a practice is contrary both to federal and to state law, although there is nothing to prevent the physician from notifying his pharmacist by telephone that such a prescription is on its way. The pharmacist must have the prescription in his possession, however, before delivery can be made.

Marijuana

It should be noted that the Harrison Narcotic Act does not regulate the production, manufacture, sale or use of marijuana. Instead, this is made the subject of separate federal regulatory legislation which is in terms almost identical with that on narcotics. A physician desiring to administer, dispense, prescribe or give away marijuana must, in order to comply with the federal act, first be registered for such purpose separately from his narcotics registration and must keep records similar to but independent of those showing disposition made of narcotics. The Wisconsin act includes cannabis, of which marijuana is a variety, in the definition of narcotic drugs, thereby making the act uniformly applicable to coca leaves, opium and marijuana.

The definition of "cannabis" was broadened by a 1941 amendment so that the state act is now identical in that respect with the Federal Marijuana Act of 1937. The term "cannabis" under the statute now includes all parts of the plant Cannabis sativa L., whether growing or not, the seeds thereof, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture or preparation of such plant, its seeds, or resin. There is exempted from the definition only the matured stalks of the plant, the devitalized seed and seed products.

It should be noted that a 1941 amendment now requires that records be kept by the physician of *all cannabis dispensed*, as is already the federal law.

State and Federal Penalties

Violation of the statutes relating to narcotics or marijuana is made a crime, and the severe penalties imposed reflect a public policy which demands that the use of these drugs be limited to legitimate medicinal purposes. For violation of the federal narcotic act the statute provides penalties varying from a fine up to $2,000 and imprisonment up to five years,

or both, to a fine up to $10,000 and imprisonment up to twenty years, or both, and for the imposition of more than one fine, or imprisonment, or both, for a given violation. The state penalties are not so heavy, being limited on the first offense to a maximum fine of $200, or a maximum jail sentence of three months, or both, and for any subsequent offense to a fine of $100 to $1,000, or imprisonment in the state prison up to five years, or both. The state statutes also provide that there shall be no prosecution under the state narcotic law where a person has been acquitted or convicted under the federal law for the same act or omission.

The penalty for violation of the federal marijuana law is a fine of $2,000 or imprisonment, up to five years, or both, and for violation of the general marijuana provisions of the state law, the same penalties as those set out above for violation of the narcotics provisions.

Patient "Narcotic Permits"

Neither the state nor federal laws confer on *any* narcotic or other governmental enforcing agent *any* authority to grant any kind of permit to any individual purporting to entitle him to have narcotics dispensed or prescribed for his personal use. The government, both state and federal, leaves this entirely up to the professional judgment and good faith of the medical profession. No such purported "permit" presented by a patient has any legal validity whatever, and, therefore, affords the physician no protection.

Death of Registered Physician

Notice of the death of a physician registered under the federal Narcotics or Marijuana Acts should be given promptly to the Collector of Internal Revenue, Federal Building, Milwaukee, by his family, administrator or executor. The collector will forward instructions as to disposition to be made of narcotics or marijuana on hand. If the family, administrator, or executor of the deceased physician's estate so desires, authority can be obtained from the Collector of Internal Revenue to sell the stock of narcotics left by the physician. Such stock can be sold, for example, to another physician who is registered under the Narcotics or Marijuana Acts. It must be noted, however, that narcotics can be sold only to a physician registered under the Narcotics Act and that marijuana can be sold only to a physician registered under the Marijuana Act. If the family, or the personal representative, of the deceased physician prefers not to dispose of the stock by sale to another registered physician, unbroken packages can be returned to the original source of purchase, but broken packages of narcotics must be forwarded by prepaid express to the narcotics district supervisor, who at present is Mr. Joseph Bell, 817 New Post Office Building, Chicago, Illinois.

Military Service of Registered Physician

In the case of a physician who enters military service and closes his office during such period, it is proper for him to retain his stock of narcotics and marijuana so long as he is careful to place it in a safe or some other place which will put it out of ordinary reach.

A medical officer in the armed forces who is authorized by the surgeon general of the Army or Navy to obtain necessary drugs and preparations for official use in the service is exempt from federal requirements of annual registration and the payment of the annual tax. A physician entering the armed forces who is certain that he will engage in no private practice requiring the use of narcotics while in service may advise the Collector of Internal Revenue at Milwaukee of this fact, and relinquish his narcotic registration number, dispose of his stock of narcotics as directed or permitted and cease to register or pay the annual tax until his return to civilian practice. However, a military, naval or contract physician who engages in any private practice which calls for the use of narcotics must retain his registration number, renew it annually, and pay the annual tax.

If the physician going into service has employed another physician to take over his practice, it will be necessary for such a substitute physician himself to be registered before he can use any of the stock on hand. One purchasing the practice of a physician going into military service must likewise be registered in order to purchase or use his narcotic or marijuana stock. The regular order form prescribed by the government must be used for this purpose.

Important Federal Requirements and Date Lines

1. A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Collector of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

2. Physicians who have registered before under the narcotics law will receive reregistration Form 678 from the Collector of Internal Revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a reregistration form on or before July 1 is under duty to request one from the collector.

3. There must accompany the registration application and annual tax a sworn inventory on Form 713 showing narcotic drugs on hand in the physician's office. This, like the reregistration and tax must be filed on or before July 1 of each year.

4. A physician may *not* order narcotics on his own prescription blank, but must use the official duplicate order book prescribed by the Collector of Internal Revenue, which may be purchased from the Collector's office, Federal Building, Milwaukee, for 10 cents. The order book may be requested on Form 679.

5. Unless a physician has registered, paid his tax, and filed an inventory, on or before July 1 of each year, it is a violation of law for him to administer, dispense, prescribe, give away or transport narcotics or marijuana until he has first complied with the law in all above respects. In the case of narcotics it is a violation of law for the physician even to be in possession of such drugs under these circumstances.

6. Fines are imposed on a physician who either negligently or wilfully fails to keep or display in a prominent place in his office the stamps denoting payment of the special annual tax on the use of narcotics or marijuana for professional purposes.

7. A physician who maintains two or more offices in different locations must register each office separately and pay the special annual tax of $1 for each.

8. The physician should report stolen narcotics at once to the narcotics district supervisor who at the present time is Mr. Joseph Bell, 817 New Post Office Building, Chicago, Illinois. Accompanying the report should be an affidavit which sets out the circumstances of the theft so far as they are known to the physician, the quantity taken, and the further fact that prior to making the affidavit local police authorities have been notified of such theft. A copy of such affidavit is to be retained by the physician and filed with his other narcotic records so as to be available at any time for inspection.

9. The following should be reported promptly to the Collector of Internal Revenue, Federal Building, Milwaukee:

(a) Removal of office. This is merely a matter of reregistration and does not require a new permit or payment of an additional tax.

(b) Discontinuance. A registered physician desirous of discontinuing either his practice or the administration, prescription or dispensing of narcotics or marijuana should notify the collector of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposing of his stock, etc.

(c) Death. See treatment under heading "Death of Registered Physician," page 86.

10. The physician should remember that if he desires to use marijuana in the course of his professional practice he must register, pay a tax and furnish an inventory on marijuana independently of those same requirements for narcotics, the latter being restricted by statutory definition to opium or coca leaves, or any compound or derivative thereof.

11. No registration is required under the Wisconsin act by physicians desirous of making professional use of coca leaves, opium or cannabis.

12. The commissioner holds that a physician who purchases a stock of narcotics beyond his reasonable needs for the ensuing ninety days is making excessive purchases. The physician who has an excessive narcotic stock on hand runs the risk of theft, ties up his money, and also runs the risk of a special investigation by a narcotics agent.

The Wisconsin office for the Federal Bureau of Narcotics is located in the Federal Building, Madison, and any communications or inquiries should be sent to the narcotics agent at the above address.

SALE OF DANGEROUS DRUGS REGULATED

The across-counter sale of barbiturates, sulfonamides, thyroid, and other legislatively designated "dangerous drugs" is now prohibited in Wisconsin except upon a practitioner's prescription. The enactment of Section 151.07 of the Wisconsin Statutes by the 1947 Legislature prohibits all but a licensed practitioner and pharmacist from preparing or dispensing such drugs, and the latter may do so only upon a written prescription from a practitioner, and may not refill except as designated on the prescription.

In addition to the drugs above mentioned, the term "dangerous drugs" and the restrictions upon their sale include cinchophen, neocinchophen, aminopyrine, amphetamine, desoxyephedrine, diethylstilbestrol, ergot, and their derivatives. One exception applies to those compounds and mixtures containing barbiturates in which the mixture contains sufficient quantity of other drugs, and the purpose of which is to produce other than a hypnotic or somnifacient action, or is intended only as a spray, or gargle or for external application, and contains other drugs making it unfit for internal administration. Physicians can render a public health service by reporting local violations of this law to police officials, district attorneys, or the Wisconsin State Board of Pharmacy.

A physician may prescribe a dangerous drug by telephone in emergency, but must furnish the pharmacist with a prescription within seventy-two hours of such call.

The law does not impose any important restriction on the dispensing physician.

Medical Aspects of Marriage Laws

THE Wisconsin Statutes impose a number of conditions which must be fulfilled before a marriage can be recognized as valid in this state. Some of these are quite unrelated to medicine, but others have medical aspects. Only those which are peculiarly within the province of the practicing physician will be indicated below.

Premarital Examinations

1. *Freedom of male from venereal disease.*—The law requires all male applicants for a license to marry to obtain and file with the county clerk a certificate to the effect that the physician has thoroughly examined him and believes him to be free from any venereal disease, the examination to have been made within fifteen days of the marriage application.

The certificate provided by statute is in the following form:

I, _____ (name of physician), being a physician, legally licensed to practice in the state of _____, my credentials being filed in the office of _____ in the city of _____county of_____ State of _____, do certify that I have this _____day of _____19____ made a thorough examination of _____ (name of person), and believe him to be free from all venereal diseases.

_____(Signature of physician)

The physician must be one duly licensed to practice in Wisconsin or in the state where the male applicant resides. The fee for such examination and certificate, by statute, shall not exceed $2. Where the applicant is an indigent the examination is made without charge, on request, by the county or asylum physician. If, in the opinion of the examining physician, a microscopic examination for gonococci is required, it shall be made by the State Laboratory of Hygiene free of charge at the request of the examining physician.

2. *Negative Wassermann tests for both applicants.*—*Both* parties to a proposed marriage shall, within fifteen days of their application, be given a Wassermann or other standard blood test for syphilis. The test must be performed either at the Wisconsin Psychiatric Institute (free of charge) or in a laboratory approved by the State Board of Health as competent to make such examination, and if the results are negative a certificate in the following form is given the applicant:

I, _____(name of physician), being a physician, legally licensed to practice medicine and surgery in the state of _____ my credentials being filed in the office of _____ in the city of _____county of _____ state of _____ do certify that_____ (name of person) was given the Wassermann or other standard blood test for syphilis at _____ _____(name of laboratory) from blood taken by _____ on the _____ day of _____ 19____ and that the result of such test was negative.

_____
(Signature of physician making laboratory test)

Note: There is provision for nonresidents securing their blood tests in their own state requiring the submission of the original certificate from the laboratory together with a statement from the State Health Officer of the state (or his representative) to the effect that he believes the laboratory competent to make the test.

A new section, Section 245.10 (6) was created by the 1945 Legislature providing that when an examination as to existence or non-existence of a venereal disease is made of a person serving in the military forces of the United States, the examination and certificate may be made by any physician serving as such in the military forces and the test may be made in any United States military laboratory and the certificate of negative findings prescribed by Section 245.10 (5) may be subscribed by any physician serving as such in the military forces. In both cases the subscribing physician shall give his military rank and station.

The State Board of Health, at its regular bimonthly meeting on November 13, 1943, approved the following rules governing the approval of laboratories for doing serological tests as required by the marriage license law:

1. For approval a laboratory for this purpose must be under the direction of a licensed doctor of medicine, unless otherwise provided by special action of the State Board of Health, who is a recognized pathologist and who devotes at least half of his time to the supervision of such laboratory.

2. Each laboratory must make application to the State Board of Health for approval under this provision.

3. If there is a change in the directorship of the laboratory it must be reported to the State Board of Health and the laboratory must reapply for approval.

It is of interest to note that the State Board of Health has ruled that it will accept tests done in the laboratories of the armed services and premarital statements of medical officers of such services as a requirement for marriage.

3. *Physician penalties.*—The statutes provide that any physician who knowingly and wilfully makes any false statement in either of the certificates set out above shall be punished by a fine up to $100 or by imprisonment up to six months.

4. *"Wassermann-fast" cases.*—Section 245.11(4) provides:

In the case of an individual whose laboratory test for syphilis results in a positive finding, when in the opinion of his attending physician the individual no longer has syphilis in an infective or communicable stage, the state board of health may review the findings and clinical evidence through a deputy state health officer and thereafter the state health officer is empowered to grant a certificate to the county clerk that the individual is not in the infective or communicable stage of syphilis if such be his best judgment.

The effect of the above subsection is to make it possible for a syphilitic applicant to marry so long as his disease is not in an infective stage. Under a rule of the State Board of Health, made in September, 1939, a case of syphilis is ordinarily not considered "Wassermann-fast," or noncommunicable, until there have been at least twenty arsenical treatments and a similar number of treatments with heavy metals, all at proper intervals. Under this subsection, however, the rule is not applied arbitrarily but is relaxed as the merits of each individual case may warrant.

To avoid unnecessary correspondence, and in order to enable the examining physician to supply lacking information, forms have been prepared and are available from the offices of the State Board of Health on which physicians requesting special consideration of noncommunicable cases may make application to the state health officer. In accordance with provisions of the above section when this form is submitted by the physician, including his statement that in his opinion the individual no longer has syphilis in an infective or communicable stage, and if, after review of the files and clinical evidence by a deputy state health officer, it is the best judgment of the state health officer that the individual is not in an infective or communicable stage, he issues the required certificate which is sent directly to the county clerk.

The Attorney General of Wisconsin has recently ruled that only applicants who have submitted to a blood test for syphilis within fifteen days of applying for a marriage license, which test resulted positively, may avail themselves of the special procedure above provided. See 29 Atty. Gen. 354.

Marriage Laws

While the physician is not professionally concerned with the marriage laws of the state except insofar as he may be directed or authorized to make antenuptial physical examinations, nevertheless he is not infrequently asked for general advice in his position as family counselor. In Wisconsin, civil, not ecclesiastical, law governs the marriage contract. It is nevertheless complicated and to a considerable extent an unadjudicated field of contract law.

Under the Wisconsin law every male person who shall have attained the full age of 18 years and every female who shall have attained the age of 15 years is capable of contracting marriage if otherwise competent. Between the ages of 18–21 years as to the male and 15–18 years as to the female, consent of the parents or guardian, or an order of the county court of the county in which the marriage license application is pending, is necessary.

An attempted marriage on the part of one who is insane, imbecilic, feeble-minded, epileptic or idiotic is absolutely null and void in this state, cannot be ratified, and may be challenged by a party to the marriage or by one validly interested therein and either during or after the lives of either or both parties to such attempted marriage. These are apparently the only marriages which are absolutely null and void from the beginning.

Where parties under age have failed to secure the consent of the parents, but have been married in good faith, their marriage is not void but merely voidable upon positive action by one of the parties or his guardian. Where the parties marry while under the lawful ages above set out, the marriage may be annulled unless the parties affirm the contract after reaching 15 years if it was the female who was not of proper age, or 18 years in the case of the male.

If a resident, who is disabled or prohibited by Wisconsin laws from marrying here, does so, such marriage is null and void for all purposes in this state. This has reference only to attempted marriage by the insane, imbecilic, feeble-minded, epileptic or idiotic, or those who have been divorced for less than one year. Other marriages, even though contracted in another state in order to avoid Wisconsin regulatory laws such as those relating to antenuptial physical examinations, are not invalid in Wisconsin.

As previously indicated, the marriage laws of this state are complicated and cannot be applied by general rule to any given situation. The physician should have a general awareness of them in the sense that all matters concerning the public welfare and particularly the field of public health come within his professional concern.

PHYSICIANS' EXEMPTION FROM JURY DUTY

Section 255.02 (2) Wis. Stats., 1947, provides exemption of all practicing physicians, surgeons and dentists from serving as jurors. This exemption from jury duty is not a disqualification, however, to act as a juror but is a mere personal privilege which the juror may claim or waive.

Physicians desiring to take advantage of their exemption should appear in court when called to act as jurymen, and should state the cause of their exemption to the presiding judge.

Care of the Illegitimate Child*

SINCE the passage of the Children's Code, the state, through the Department of Public Welfare, has been responsible for protecting the interests of children born out of wedlock.

The Wisconsin Statutes provide in Section 46.03 (11):

> "The Board shall promote the enforcement of all laws for the protection of mentally defective, illegitimate, dependent, neglected, and delinquent children except laws whose administration is expressly vested in some other State Department. To this end it shall cooperate with Juvenile Courts and all licensed Child Welfare agencies and institutions of a public or private character, and shall take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made or is not likely to be made."

Section 46.03 (12) further provides that

> "When notified of the birth or expected birth of an illegitimate child the Board shall through the advice and assistance of the mother, or, if necessary, independently of the mother, see to it that the interests of such child are safeguarded, that appropriate steps are taken to attempt to establish the paternity and that there is secured for him the nearest possible approximation to the care, support and education that he would be entitled to if born of lawful wedlock."

The Department of Public Welfare delegates its responsibility in this field to the Division of Child Welfare. Reports of children born out of wedlock come to the Division through many sources—the mother herself, relatives, physicians, hospitals, attorneys, pastors, schools, private agencies, and friends. Some mothers need very little help. Others are completely bewildered. The Division of Child Welfare refers each situation to a social worker on its staff, to a County Children's Worker, or to a private children's agency. A social worker is requested to give consultation and assistance to the mother in making plans for herself and her child.

The child welfare agencies licensed to give this type of service are:

The Children's Service Society of Wisconsin, 734 North Jefferson Street, Milwaukee 2.

The Lutheran Welfare Society, 3005 West Kilbourn Avenue, Milwaukee 8.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Catholic Child Welfare Bureau, 3222 South Avenue, La Crosse.

Catholic Social Welfare Bureau, 625 North Milwaukee Street, Milwaukee 2.

Jewish Social Service Association, 2218 North Third Street, Milwaukee.

Catholic Welfare Agency, 1200 Fifteenth Avenue, East Superior.

If the mother's situation is known to the Division of Child Welfare or to a social worker before a child is born, it is possible to give assistance in arranging for confinement plans. For the unmarried mother who wishes to keep her child, plans may be worked out for her confinement in her own community. She may need advice as to how to proceed with action against the alleged father in order to have paternity established as well as to get a financial contribution from him toward the support of the child. Many times the unmarried mother wishes to release her child for adoptive placement. All of the child welfare agencies listed above are licensed to place children for adoption. They are also able to help in making plans for confinement as well as plans for the future of the child. Many of these agencies maintain district offices throughout the state. Any referral that is made to the main office would be forwarded on to the district office located closest to the home of the mother.

Maternity Homes

The illegitimately pregnant girl is often quite anxious to leave her home community so that her condition may not be revealed to other members of her family or friends. Arrangements may be made for her care by a private physician of her own choice. Confinement is possible in private hospitals. Other mothers choose to enter maternity homes. There are several homes in the state offering this type of care:

Salvation Army Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.

St. Mary's Mothers' and Infants' Home (Catholic), 403 South Webster Avenue, Green Bay.

Summit Hospital, Oconomowoc.

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* Prepared for The Journal by Miss Dorothy Waite, Division of Child Welfare, State Department of Public Welfare, State Capitol, Madison.

Admission to these hospitals may be made either by writing the hospital directly, through contacting the Division of Child Welfare, or through one of the licensed Child Placing agencies. All Maternity Homes require a negative smear, Wasserman, and throat culture before the patient is admitted. Fees for care at the hospitals vary between $50 and $100. This includes the girl's prenatal care, confinement, and care after the birth of the child until such time as her own plans are completed and she is ready to leave the hospital. At Summit Hospital the girls may remain long enough to work out their entire bill. At the Maternity Homes the girls are given some duties which contribute to the cost of the care which they receive. Formerly it was necessary for the unmarried mother to remain with her child in certain Maternity Homes for a definite period of time after the child's birth. This is no longer true. The mother may leave the Maternity Home any time after the birth of the child when the attending physician feels that she is physically able to leave and there is a satisfactory plan made for her child.

Plans For the Child

Upon the mother's discharge from the hospital there are several plans which she may consider for the care of her child, and the decision as to the final plan must be her own. (1) She may take the child with her to her own home or the home of relatives. (2) The child may be placed in an approved foster home under the supervision of either a licensed Child Placing Agency or a County Children's Worker, pending the time when the mother definitely decides as to whether she wishes eventually to take the child into her own home, whether she plans to marry the alleged father, or whether she wishes to release her child permanently for adoptive placement. The licensed Child Welfare agencies listed earlier are licensed to place children in adoptive homes. The advantage of working through a licensed agency, is that neither the mother nor the adoptive parents have any contact with each other. The mother is given time to make up her mind fully whether she wishes to keep her child or whether she wishes definitely to release it. Although this method of placement takes longer than it would if more hasty placements were made, it has been proved that in the long run the child is happier, the unmarried mother has been given time to carefully think out the plan so that she will have no regrets. The adoptive parents are assured that a child will be placed in their home who will become a very real member of their family group.

The laws regulating the placement of children place definite restrictions on any person or agency not licensed to perform this function. If an unmarried mother comes to a physician and expresses her desire to release her child for adoption, we would suggest that the physician immediately refer her to the Division of Child Welfare or to one of the licensed Child Welfare agencies mentioned earlier in order to avoid violating this law.

Status on Child Placement

"48.37 Licenses; Records; Reports. (1) No person other than the parent or legal guardian. and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed Child Welfare Agency.

"48.40 Violations. (1) Whenever the State Department of Public Welfare shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a Child Welfare Agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it either may issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of Section 48.41.

"48.41 Penalties. (1) Any person who shall act as a Child Welfare Agency without a license as provided in this chapter or who shall violate any of the provisions of the Statutes relating to the organization, conduct and operations of Child Welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the County Jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation."

If questions arise regarding particular cases, it is suggested that the physician contact the Division of Child Welfare at 315 South Carroll Street, Madison, Wisconsin.

Outline of Laws Governing Collection of Accounts

THIS article is designed as an outline of some of the more important every-day aspects of collection law, and to suggest certain practical devices of aid in the collection of accounts of special interest to the physician. Your attorney can prepare for you model forms of promissory notes, judgment notes, and chattel mortgages. Their use may facilitate, but will be no guaranty, of payment. In the final analysis, a sympathetic understanding of a debtor's position and a willingness to cooperate with him are surer means, as a general rule, of ultimate collection than resort to legal action. In involved matters, in the actual trial of cases in Justice Court, or where large sums are involved, services of a local attorney should be secured.

Liability For Services Rendered

Generally, the person who contracts for the services is responsible for its payment, but in certain cases there are qualifications of that rule.

Husband-wife.—A husband is liable for the reasonable value of *necessities* furnished his wife and minor children, chiefly dependent upon him for support. Essential medical services are necessities. However, he is not liable for bills which his wife incurred before their marriage, or after they are divorced. A married woman living with her husband is not liable for medical services out of her separate estate, unless she *expressly* contracted for them upon her own credit, or unless she guaranteed payment (in writing) by her husband.

Guardian-ward.—Guardians are empowered by statute to apply the personal property and the income from the property "as far as may be necessary for the suitable education, maintenance, and support of the ward . . ." Sec. 319.26 Wis. Stats. But when the guardian has made adequate provision for the care and attention of his ward, a volunteer assuming to perform services or furnish supplies for the ward without knowledge or authority of the guardian cannot recover the value of such services or supplies.

Expenses of last illness.—Such expenses, being obligations contracted for during lifetime, must be presented as claims against the estate, unless they were expressly contracted for by someone other than the decedent. Such claim is a preferred claim (Sec. 313.16 Wis. Stats.) and is entitled to be paid in full prior to the payment of other obligations except those for funeral expenses.

Claims Against Decedents and Bankrupts

Decedents.—In the administration of an estate, the county court fixes a time during which creditors must present their claims. Notice is given by publication, and unless the claim "be filed within the time limited for that purpose, (it) shall forever be barred." Sec. 313.08 Wis. Stats. The time for filing can be extended, but not to exceed two years, upon proper application (showing cause therefor) filed with the court within sixty days after the expiration of the time set. Claim should be filed with the register in probate; should state fully the nature and amount of the claim, and the correctness of the items; and the amount should be sworn to before a notary public. County courts will furnish, upon request, the proper blanks to be used in filing the claim. Under an amendment to the law made by the 1939 legislature, a charge of 25¢ is made in Milwaukee county as a fee for filing any claim against the estate of a deceased. In counties other than Milwaukee, the clerk of county court is permitted to make a small charge, but in practice this is not done.

Claims for the expenses of the last sickness of the decedent, being preferred, may be ordered by the court to be paid in advance of general claims if the former have been presented within sixty days after the date of the original order. Sec. 313.03 (2) Wis. Stats.

Bankrupts.—Bankruptcy is a discharge of all debts which have been *listed* on schedules filed by the debtor, with certain exceptions. Claims, duly verified before a notary must be filed with the referee in bankruptcy ordinarily within six months after the first meeting of creditors. Creditors are given notice by mail (and by publication) of the first meeting, at which, if they desire, they can be present to question the debtor. A receiver is appointed to take over the assets, if there are any, and distribute them among the creditors.

A debtor who has received his final discharge in bankruptcy may still render himself liable for claims which have been proved and allowed. He may do so either by making a payment on the account to the creditor or by executing a written agreement to pay the account.

Matters Preliminary to Collection

Office records.—Collection of accounts may be simplified if in the first instance the doctor obtains the full name and address of the patient. He should insist upon the middle name or initial especially in the case of such common names as Johnson, Smith, etc. If treatment is for a minor, the name and address of the parents should be obtained, and if for a married woman, her husband's name, occupation, and employer. If children are not minors but are living at home, obtain the parent's name as well, since it may simplify the matter of locating the patient later. Physicians who make a practice of jotting

down information regarding the patient's relatives, place of employment, etc., often find such information invaluable in locating them later, and frequently use that information in determining the charges to be made.

Locating debtor.—When the debtor moves, his new address can often be obtained from his ex-landlord, or from neighbors. If he has a telephone, the telephone company will supply the new address. In some cities it is mandatory for trucking companies to report all removals which they handle, and an alphabetical list of such removals and new residences is kept at the police station. If gas or light is charged directly to the debtor at his new residence, the gas or electric companies will have information in their files which can often be obtained. If he owns personal property upon which a tax is levied, his address can be obtained at the assessor's office. If he owns a car, and it is licensed in his name, the Registration Division of the Motor Vehicle Department at Madison will have his address. If a debtor is in the habit of buying on installment contracts, the contracts are usually filed with the register of deeds, and the address can be ascertained by checking the files, which are arranged alphabetically. Again, the importance in the first instance of obtaining the full name must be stressed, for, without that, the tracer is under a handicap in using any of the above methods.

The post office maintains, in connection with its registered mail service, a "tracing" service. For 31¢ in addition to the regular registration and return receipt fee, a letter will be delivered to the addressee personally, and none other, if he can be located, and the return receipt will show the address where the letter was delivered.

Informal Methods of Collection

Collection letters.—The Attorney General has ruled that a letter stating that if a person does not pay, the sender will "take it out of his hide" constitutes an offense under the blackmail statute, Sec. 340.45 Wis. Stats. In effect, this statute provides that any person who shall maliciously threaten to accuse another of any *crime* or *offense* or *threaten to do injury to the person, property, business or profession of another*, with intent to extort money, may be prosecuted therefor. Collection letters should be dignified and confined to the purpose for which intended. Collection by postcard is forbidden by postal regulations.

Promissory notes.—Parties may, by contract, provide for interest rates of 10 per cent or less per year; 5 per cent is the legal rate if none other is specified in the note. Sec. 115.04 Wis. Stats.

A judgment note differs from an ordinary promissory note in that it provides a method of taking judgment including costs and attorney's fees, without service of process. It is ordinarily preferred, therefore, since it provides remedies that may be sought and enforced expeditiously.

Chattel mortgages.—Under some circumstances, it may be advisable to secure the note by obtaining from the debtor a chattel mortgage. The mortgage must describe accurately and in detail the property which it covers, and be filed with the register of deeds in the county where the property is situated if it is to protect the creditor against subsequent mortgages by the same debtor. Sec. 241.10 Wis. Stats. Chattel mortgages must be signed by the mortgagor and by his wife when exempt property is covered, and her signature witnessed by two persons. Sec. 241.08 Wis. Stats. They may be taken on any type of personal property. Such a mortgage is valid for three years, and can be extended for additional one-year periods by filing an affidavit with the register of deeds, describing the property, the prior mortgage, and the interest the mortgage holder has therein. Sec. 241.11 Wis. Stats. Provision is made for foreclosure and sale of the mortgaged property, upon proper notice to the mortgagor. Sec. 241.13, Wis. Stats.

Wage assignments.—An assignment of wages by a married man of salary or wages which are exempt from garnishment is generally valid for only two months in advance. However, no assignment of such wages or salary is valid at all unless signed by his wife, if she be at the time a member of his family, in the presence of two disinterested witnesses. Sec. 241.09 Wis. Stats.

Wages to be earned under an employment not then in existence are not assignable. The law recognizes no assignment of future earnings unless such earnings are based on an existing contract of employment. *Porte v. C. & N. W. Ry. Co.*, 162 Wis. 446 (1916).

Collection by Suit

Statute of limitations; malpractice.—Accounts for physicians' services become outlawed if six years have elapsed since the date of last payment, or since the last item of work was done, if no later payments were made. But, if the debtor "shall depart from and reside out of this state . . ." the statute of limitations is suspended during the time he is absent. Sec. 330.30 Wis. Stats.

It should be kept in mind that in order to avoid a possible counterclaim for malpractice, the physician should wait at least two years before bringing suit. (See the article on page 61 relative to malpractice.) Under the provisions of Section 330.19 (5), Wis. Stats., the complainant, if he has not already instituted action by summons and complaint in a personal injury action (including malpractice), must give notice within two years after the happening of the event which caused the damage claimed; and if such notice has not been given, his claim is barred.

Where suit is brought.—Actions involving less than $200 are commonly brought before a justice of the peace because the procedure there is usually more speedy, and the costs are less than in courts

of record. While a justice court is not a court of record, the plaintiff or defendant, except persons under 21 years of age, may appear therein "by an attorney, agent or in person and conduct or defend any action." 301.20 Wis. Stats.

The jurisdiction of a justice of peace extends only to actions involving an amount of $200 or less, with certain exceptions, and only within the county where he is elected. The service of a justice court summons outside the county of issuance is ineffective as contrasted with a summons out of circuit court which is effective when served anywhere in the state. Therefore, if suit is against a nonresident of the county, it is usually forwarded to that county or brought in circuit court. Special courts, such as the Superior Court of Dane County and various municipal courts, have been created by the legislature from time to time, having such territorial jurisdiction as is granted by the act creating them.

Costs and fees in court actions.—Costs and fees vary, depending on the court in which action is brought and the type of action involved. In general, the costs are less in justice courts than in courts of record.

Justice court: Ordinarily if a summons is issued and the action settled thereupon without further proceedings the justice fees average $2. If the justice enters judgment by default, his fees average $3, but if the case is contested, the fees range from $5 up, depending upon the length of trial, number of witnesses, and amount of testimony (Chap. 307, Wis. Stats.).

The officer serving the summons is entitled to 10¢ per mile for travel, in addition to the fee set by statute for service. Sec. 60.55 (10) Wis. Stats. Witnesses are entitled to $2 a day plus 5¢ per mile travel. Sec. 325.05 Wis. Stats.

The costs and fees are added to the judgment, to which may be added attorney's fees in the amount set by statute, if the party claiming them is represented by an attorney, and the opposing party appeared to prosecute or defend the case. Sec. 307.02 (4) Wis. Stats.

Courts of record: Costs and fees differ in that the judge is on a salary basis, and collects no fee for his services. A filing fee and state tax amounting to $3 for the summons is provided. Sec. 59.42 Wis. Stats. Other costs depend upon the individual case.

Lien of judgment.—A judgment, or transcript thereof, when filed with the clerk of the circuit court of the county in which the debtor has real estate, is a lien on such real estate (except his homestead) as the debtor may have at the time of docketing or for ten years thereafter. Sec. 270.79 Wis. Stats.

It should be noted that a judgment rendered in justice court is not a lien on the debtor's property unless the judgment creditor has a transcript of it filed with the clerk of circuit court. Thereupon it "shall be deemed the judgment of the circuit court . . . ." Sec. 270.75 Wis. Stats. The justice is entitled to 25¢ for the transcript, and the clerk charges $1 to enter it.

While such judgments remain liens for only ten years, an action to collect the judgment can be brought at any time during the 20 years next after docketing. Actions to collect judgments of justice court (which have not been filed with the clerk of circuit court) are barred after a lapse of five years. Sec. 303.07 Wis. Stats.

Collection of Judgment

Introductory.—The fact that suit is resorted to in the enforcement of a claim is no assurance that the money will be collected, for many debtors are not in a position to pay many of their bills. Therefore, before resorting to suit, it is advisable to ascertain whether or not the debtor is in a position to pay the judgment, in case it is obtained.

Garnishment.—Garnishment proceedings can be instituted at any time after the summons in the original action is issued, or upon the judgment itself. Sec. 267.01 Wis. Stats. While commonly thought of as a method of reaching the wages paid to the debtor, the process of garnishment can be instituted to attach any property whatever, real or personal, due the debtor and in the hands of a third person, unless it is exempt. Various items reached in this manner are: money due on contract or salary, drafts or notes belonging to the defendant and other personal property. By statute the person who owes the debtor is liable as to debts due or to become due at the time the garnishee summons is served upon him, but the debt must be due absolutely and without depending upon any future contingency; for example, under a building contract under which nothing was due until completion of the building, garnishment was ineffective unless served after completion of the building. *Mundt v. Shabow*, 120 Wis. 303, (1904).

Executors and administrators are not subject to garnishment of moneys belonging to the estate they represent, at least not until their accounts are settled and they have been ordered by the court to pay over the respective shares to legatees or distributees. As a general proposition any property or fund in the custody of the law is immune from garnishment, as is property in transit by common carrier. Trustees, guardians, and assignees in bankruptcy are ordinarily not subject to garnishment of funds which they hold for the benefit of others. However, by Section 272.30 Wis. Stats., real estate held in trust or for the use of another is liable for debts, judgments, execution and attachment against the person to whose use it is held.

Execution.—An execution is a written command by a court to the sheriff, after a judgment is obtained, directing him to execute the judgment of the court. In the ordinary case, it directs him "to satisfy the judgment out of the personal property of such debtor, and if sufficient personal property can-

not be found, out of the real property belonging to him . . ." Sec. 272.05 (1), Wis. Stats.

All of the property of the debtor, except that exempt by statute, is liable for his debts, that is, bank notes, money, bonds, stocks, equities in goods mortgaged or pledged and real estate. The officer conducting the sale must give twenty days' notice of sale of personal property, and post notice publicly in three places, and must give three weeks' notice (by publication in addition to posting) in the case of real property. Sec. 272.29, 272.31 Wis. Stats.

Exemptions.—The statute sets out at length (Sec. 272.18 Wis. Stats.) what property is immune from seizure by garnishment, execution, attachment, etc. to satisfy the debts of a person. Relevant provisions include:

a. Earnings. The debtor is entitled to an exemption of 60% of his earnings, including the earnings contributed by minor children, but not less than $60 or more than $100 for the month preceding the issuance of the writ and not less than $180 or more than $300 for the preceding three months. In addition he is entitled to an extra $10 per month exemption for each child under 16 years dependent on him for support. This statute applies only to persons who have families dependent upon them for support. Sec. 272.18 (15) Wis. Stats. Thus most single people are excluded. Earnings include proceeds from the sale of crops, livestock, dairy products and other products grown or produced by a person to which his personal effort or that of his minor children has contributed.

b. Automobiles. Any automobile used or kept for the purpose of carrying on the debtor's trade or business, and not exceeding $400 in value, is exempt. If it is worth more than $400, it can be seized and sold, the $400 paid the debtor and the excess paid to the creditor. Sec. 272.18 (6) Wis. Stats.

c. Tools, etc. Tools, implements and stock in trade of a person used or kept for the purpose of carrying on his trade, not exceeding $200 in value, are exempt, Sec. 272.18 (8). In addition Sec. 272.18 (6) sets out various farm implements, to the value of $300; eight cows, ten swine, fifty chickens, two horses or mules and food for them for a year.

d. Wearing apparel; household goods. All wearing apparel of the debtor and his family; all beds and bedding used by the debtor and his family; all cooking utensils and other household furniture not specifically enumerated, not exceeding $200 in value; and, under a 1947 amendment, jewelry and other articles of personal adornment not exceeding $400 in value are exempt, as are certain other personal items. Sec. 272.18 (5) Wis. Stats.

e. Other personal property. Numerous specified articles are exempt, and the statute, Sec. 272.18, should be referred to before attempt is made to satisfy judgment by execution or otherwise.

f. Homestead exemption. The statute provides for a homestead exemption of not more than 40 acres of land, when used for agricultural purposes, and, in the case of nonagricultural land, one-quarter acre and the dwelling thereon owned and occupied by the debtor, to the amount of $5,000. Sec. 272.20 Wis. Stats. If the land is in a village or city, or not used for agricultural purposes, the amount is limited to one-fourth of an acre including the dwelling thereon.

g. Exemptions lost by fraud. A 1947 amendment provides that any exemption granted by this section of the statute may be denied if, in the discretion of the court having jurisdiction, the debtor procured, concealed, or transferred assets with the intention of defrauding his creditors.

Attachment.—Attachment differs from execution in that it is available at the time an action is begun. It may be one of the methods of beginning an action. It consists in having the sheriff or constable seize property of the debtor and hold it until further direction of the court. It is available only under certain conditions set out in Section 266.03 Wis. Stats., and is used primarily in cases where the debtor is about to move away or dispose of his property—situations in which it is essential to act quickly to tie up the property of the debtor. If, upon trial of the action, the plaintiff is awarded judgment, the property is sold as by execution, and the proceeds applied likewise. Sec. 266.23 Wis. Stats.

Before a warrant of attachment is issued, the plaintiff or somebody in his behalf must file with the court an affidavit stating that the defendant is indebted to the plaintiff in an amount over $5 in justice court or $50 in circuit court due on express or implied contract or judgment, and stating reasons why an attachment should issue. The court issues the warrant which can be served immediately and the goods attached. It should be kept in mind that the ordinary rules of exemption apply to attachment as well as garnishment and execution proceedings. It is important to note that the attachment only creates a lien which may be lost unless within a reasonable time after judgment the creditor issues execution. Special provision is made for sale of perishable property. Sec. 266.14 Wis. Stats.

Remedies supplementary to execution.—Sometimes it is suspected that the debtor has assets which are not exempt, but which have been concealed or for some reason have escaped execution. Supplementary proceedings in aid of execution can be invoked under Chap. 273, Wis. Stats., and an order issued by the court, or a judge of the county to which execution was issued (not a justice of peace,) requiring the debtor to appear and "answer concerning his property." Sec. 273.03 Wis. Stats. Witnesses can be subpoenaed if necessary, and the debtor questioned upon oath as to his assets. If assets are discovered, not exempt, the court can order them applied toward satisfaction of the judgment. This procedure is available when execution is returned unsatisfied.

A receiver may be appointed to collect assets which may be due the debtor from others. Sec. 273.04 Wis. Stats.

The G. I. Bill of Rights and the Physician

THIS Article is a summary of the recent amendments to Public Law 346, known as the Servicemen's Readjustment Act, or more commonly as the "G.I. Bill of Rights." It is prepared in conjunction with the Veterans Administration.

Educational Benefits: (1) *Eligibility of Veterans:* Honorably discharged physician veterans of World War II are eligible for educational benefits for a period of time equal to one year plus the duration of their active duty since September 16, 1940 and prior to the termination of the war, not including time spent on active duty in A.S.T.P. or Navy V-12 programs. In no case may the period of education exceed four years.

Certain benefits of the law relating to education and to loans are available to veteran officers while they are on terminal leave. The institution in which such a veteran undergoes training can be paid tuition fees during that period but the veteran will not be entitled to subsistence until after his discharge. However, such attending benefits as allowances for books, laboratory fees, and so forth, will be extended as soon as educational requirements are met, even though the schooling starts prior to final discharge.

It is necessary for the veteran to establish his eligibility by filing an application form 1950. A certified copy of his discharge or photostatic copy should accompany the application. In return, the veteran physician receives a Certificate of Entitlement which indicates the duration of training to which he is entitled. This certificate must be submitted to the approved hospital for endorsement. Benefits cannot be paid until the Certificate of Entitlement is turned over to the approved hospital or training institution.

(2) *Short Intensive Training Courses of Less than Thirty Weeks:* Institutions providing review and refresher courses of less than thirty weeks, having regularly established fees, must be approved by the appropriate state agency and must arrange for tuition payments with the Regional Office of the Veterans Administration. For review and refresher courses there will be charged against the veteran's time period of eligibility the proportion of an ordinary school year which the cost of the course bears to $500. For example, if an eligible veteran elects a two-month refresher course for which $250 is paid, there will be charged against the veteran's period of eligibility for training, not two months, but a half of the ordinary school year, since $250 is one-half of $500.

(3) *Subsistence Allowance:* The subsistence allowance for a veteran without dependents is now $65 per month and for a veteran with dependents $90 per month. The total, however, of the subsistence allowance plus the stipend or other wages the doctor receives from the hospital may not be more than $175 per month in the case of a veteran without dependents, or $200 for a veteran with dependents, if the total subsistence is to be paid.

Hospital Residencies and Postgraduate Continuation Courses: Instruction furnished to the physician veteran should be regarded as institutional training. This applies to all acceptable residency hospitals, whether or not they are affiliated with a medical school. This ruling means that otherwise qualified physician veterans pursuing training in connection with residencies or fellowships are eligible for subsistence benefits and that approved hospitals are eligible to apply for tuition remuneration.

Although the Veterans Administration has established the general principle that hospitals conducting acceptable residencies are eligible for participation under the bill, it is still necessary for each residency hospital to seek approval as an individual institution from the appropriate state agency.

It is advisable for each physician to check personally on the approval for residencies and refresher courses at the hospital or institution where he intends to register.

Loan Provisions: The loan provisions of the bill can assist the veteran physician in securing a home or in purchasing an existing practice. All details of the transaction may be handled through a local lending agency, most of whom are now familiar with the loan guarantee privilege. Briefly, this benefit entitles the doctor making the loan to have the government guarantee a portion of his loan from the bank. The government will guarantee home loans up to 50 per cent of the loan, or $4,000, whichever is the lesser amount, or 50 per cent of a business loan up to $2,000, and a combination of the two, the aggregate of which cannot exceed the maximum of whichever type of loan was first sought. Interest on the guaranteed portion of the loan is paid by the government during the first year.

Wisconsin Veterans Medical Service Agency

IN NOVEMBER 1946, the House of Delegates of the State Medical Society of Wisconsin created this agency to represent its members in obtaining authorizations from the Veterans Administration in treating veterans with service-connected disabilities.

The Wisconsin Veterans Medical Service Agency represents the physicians, operates on a nonprofit basis, and serves both the physicians and the veterans alike.

The Council of the State Medical Society has created an Operating Committee to direct this program. The committee is composed of:

J. S. Supernaw, M.D., *Chairman,* Madison
W. C. Finn, M.D., Fond du Lac
Maurice Hardgrove, M.D., Milwaukee
H. S. Fuson, M.D., Eau Claire
F. D. Weeks, M.D., Ashland

The director of the agency is Thomas J. Doran, with offices located at 119 East Washington Avenue, Madison. The telephone number is Gifford 6620. You are privileged to reverse charges on calls regarding immediate hospitalization of veterans. If emergency hospitalization in a local community is necessary, the doctor must notify either the agency or the Veterans Administration within seventy-two hours of the veteran's entrance into the hospital.

As you know, the Veterans Administration cannot authorize hospitalization in local communities if beds are available in Veterans Administration facilities. If your patient is in need of hospitalization and *can be moved* to a Veterans Administration hospital, telephone or wire collect:

Chief Admitting Officer, Wood, Wisconsin
Telephone: Mitchell 7125
or
Chief Medical Officer of Out-Patient Services
Veterans Administration
342 North Water Street, Milwaukee, Wisconsin
Telephone: Broadway 7780

Your State Medical Society, through this agency, is at the service of its participating physicians.

A new fee schedule went into effect on December 1, 1947. You will notice a different set of code numbers and a different set of maximum fees. It will save everyone time if you will fill in your charges for services on Form 200.

Whenever it is necessary for you to do any laboratory work either on your first request or on subsequent requests, be sure to identify all necessary laboratory work by code number. *The laboratory work will no longer be included in the office visits or examinations.*

PROCEDURES TO FOLLOW IN DEALING WITH THE WISCONSIN VETERANS MEDICAL SERVICE AGENCY

The Purpose of the Agency

1. The Wisconsin Veterans Medical Service Agency was created by the House of Delegates of the State Medical Society and started operation November 1, 1946. The purpose of the agency is to act as a clearinghouse for the doctors in obtaining authorizations to treat veterans with service-connected disabilities. The services of the agency are available to all members of the State Medical Society. The agency is a part of the State Medical Society, and the officers of the State Medical Society have signed a contract and agreed on a fee schedule with the Veterans Administration.

Reasons For Establishing the Agency

1. To make possible a free choice of physician for the veteran with a service-connected disability.

2. To standardize the procedure for requesting authorization and reporting and billing services rendered to veterans.

3. To interpret the rules and regulations of the Veterans Administration to the doctors and also represent the views of the doctors to the Veterans Administration.

4. To assure the Veterans Administration that adequate medical services will be available to all veterans in the state of Wisconsin.

5. To establish a fair and equitable fee schedule between the Veterans Administration and the hometown doctor.

6. To audit the doctors' bills and present them for payment to the Veterans Administration.

7. To collect the bills from the Veterans Administration and pay the doctors directly.

Who is Eligible for Outpatient Treatment?

Veterans with service-connected disabilities.

1. Any veteran who has an illness or a disabling condition which has been certified by the Veterans Administration to have been caused or aggravated by active service in the United States Armed Forces.

a. Some veterans have established their claim* for their service-connected disability. Other veterans are eligible for treatment on *prima facie eligibility* because their claims are pending adjudication.

* *What is a claim?* Any document in writing signed by a veteran which claims a service-connected disability shall be deemed a claim for out-patient treatment or emergent hospitalization.

2. *Veterans Training Under Public Law 16.* Veterans receiving training under Public Law 16 (those with vocational handicaps resulting from service-connected disabilities) are entitled to outpatient treatment not only for their service-connected disabilities but also for *any* disability that may interfere with the pursuit of training.

How Does a Veteran Get Medical Care?

1. The veteran may choose his family doctor or any physician who is practicing in his community who is a member of the agency when he needs medical care for his service-connected disability. (If the veteran chooses a physician who is not a member of the agency, direct contact must be made with the Veterans Administration.)

2. He may also go directly to one of the Veterans Administration facilities. (Although Veterans Administration medical facilities must be utilized to their fullest extent, this does not mean that the veterans will arbitrarily be ordered to field stations. If veterans establish to the satisfaction of the chief medical officer of the Veterans Administration regional office that reporting to a field station would work unnecessary physical hardship or cause excessive loss of time from employment, fee-basis doctors may be utilized. In any event, final decision rests with chief medical officers of the Veterans Administration regional offices.)

How Does the Physician Request Authority For Treatment?

He requests it by filling out Form 100.

1. Forms 100 are provided each physician who is a member of the agency. (Request additional Forms 100 from the agency.) This form is a standardized procedure by which each physician requests authority to treat veterans with service-connected disabilities. On page 99 is a sample Form 100 with explanations regarding each item of the Form 100. This Form 100 is only a request for authority to treat the veterans. It must reach the agency within fifteen days after the first treatment or examination is given to the veteran. If it does not reach the agency within fifteen days, the starting date of the authority can only be backdated fifteen days prior to the receipt of the Form 100 in the agency office. Be sure to have the veteran sign the form on the same date that he receives his first treatment or examination.

2. Under last year's agreement, the doctor was authorized a code number 166, routine office examination including treatment, for filling out Form 100. This same procedure included all the necessary laboratory work that had to be done, and it proved to be unfair to the doctors who had to do considerable laboratory work. Under this present fee schedule, the doctor will be paid a code number 0013, which is the first office visit. The doctor should also request authorization by code number for all the necessary laboratory work that must necessarily be done in order to adequately fill out Form 100. As you will note in the fee schedule, the first office call is $3.50, and the subsequent office calls are $2.50. In requesting the number of office calls, be sure to use the code numbers.

3. The Veterans Administration advises the physician in the handling of difficult cases to request hospitalization so that the extensive laboratory work and diagnostic work can be completed in a Veterans Administration hospital, and then have the patient returned home to be cared for by the family physician.

How Does the Physician Get Authority to Treat the Veteran?

1. As soon as the Form 100 is received in the agency office, it is checked to make sure that the minimum amount of information is on the form, and it is then immediately cleared with the Veterans Administration to determine whether the chief complaint of the veteran is a service-connected disability. If the veteran's claim and medical record show the ailment to be service-connected, the Veterans Administration immediately issues to the agency the authority requested by the physician to treat the veteran. Upon receipt of this information from the Veterans Administration, the agency sends out Form 200, which is the doctor's authority to treat the veteran and his bill for the services he renders.

2. The Veterans Administration can only authorize medical care for a thirty day period. The authorized work must be completed within this thirty day period if payment for services is to be expected. The starting date of the authority and the expiration date of the authority are clearly stated in line 3 of the Form 200. As soon as this period has expired, return the Form 200 to the agency itemizing your bill and request further treatment for your patient in the space provided on the bottom of Form 200 for the next thirty days. Again your request for continued treatment must reach the Agency office within fifteen days from the expiration date on Form 200. This request for continued treatment is immediately cleared with the Veterans Administration, and if authorization is provided, a new Form 200 is immediately sent out to the physician. This is the procedure for continued treatment.

3. Anytime there is a break in the treatment of your patient for at least thirty days, request your authority to start treating the patient again by Form 100. If you did not request enough authority, namely, enough office calls, home calls, or laboratory work to cover the thirty day period, request the necessary additional work by a letter to the agency. The types of treatment can be found in the fee schedule by checking the index. A separate code number is reserved for each item of medical service and in requesting authority to treat your patient, please use the exact code number so there will be no misinterpretation of the type of work you wish to do on your patient.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY, Madison, Wisconsin
REQUEST FOR AUTHORITY FOR TREATMENT

C—Number (A) → SEE NEXT PAGE

DATE ENTERED SERVICE

TO BE FILLED IN BY VETERAN

1. LAST NAME — FIRST NAME — MIDDLE NAME OF VETERAN | PRESENT ADDRESS (STREET-CITY-ZONE-STATE) | COUNTY

2. LEGAL ADDRESS | RANK AND ORGANIZATION | SERVICE-SERIAL NO (B)

3. DID SERVICE TERMINATE IN HONORABLE DISCHARGE? ☐ YES ☐ NO. OR CERTIFICATE OF SERVICE ☐ YES ☐ NO | DATE OF DISCHARGE

4. HAVE YOU FILED A CLAIM FOR DISABILITY PENSION OR COMPENSATION? (C) ☐ YES ☐ NO. IF ANSWER IS NO, I DESIRE THAT THIS APPLICATION SERVE AS A CLAIM FOR THE DISABILITY INDICATED BELOW ☐ YES ☐ NO. Date Entered Service (D)

5. ARE YOU NOW RECEIVING A DISABILITY PENSION OR COMPENSATION? ☐ YES ☐ NO. Date Discharged

6. HAVE YOU RECEIVED HOSPITAL OR DOMICILIARY CARE? ☐ YES ☐ NO IF ANSWER IS YES, SPECIFY WHERE AND WHEN. (E)

7. **CERTIFICATION**—I hereby certify that the answers to all questions are true and complete to the best of my knowledge and belief, and the foregoing questions are answered and made a part hereof with full knowledge of the penalty provided for making a false statement as to material fact in connection with this application. (*The penal provisions are Title II, Public 2, Seventy-third Congress, annotated, Section 15.*)

I hereby make application for treatment for disease, which I certify, to the best of my knowledge, was incurred or aggravated while in military service, and I have not been advised by the Veterans Administration that my claim for this disability has been disallowed.

SIGNATURE OF ☐ VETERAN ☐ RELATIVE OR ☐ FRIEND (CHECK ONE) | ADDRESS OF SIGNEE IF OTHER THAN VETERAN | DATE (F)

TO BE FILLED IN BY DOCTOR

8. MARITAL STATUS ☐ MARRIED ☐ WID. ☐ SINGLE ☐ SEP. ☐ DIV. | AGE | RACE | OCCUPATION (G) | BIRTHPLACE

9. FAMILY HISTORY | 10. CHILDREN (NO. AND AGES)

11. PREVIOUS DISEASES AND INJURIES | 12. MENSTRUAL HISTORY: DURATION: | REGULAR: ☐ YES ☐ NO. PAIN - 0 1 2 3 4 | 13. LEUKORRHEA: 0 1 2 3 4 LAST PERIOD

14. CHIEF COMPLAINT (H) | 15. OPERATIONS

16. CLINICAL HISTORY (J)

17. PHYSICAL EXAMINATION (*Check areas showing positive findings*) (K)

HEIGHT	WEIGHT	LOSS OF WEIGHT	LOSS OF STRENGTH (BASIS IV)

URINE:	REACTION	SP. GR	ALB	SUGAR	MICRO

BLOOD: HB RBC WBC

☐	HEAD	☐	RECTAL	☐	SKIN
☐	MOUTH	☐	EXTREMITIES	☐	PULSE
☐	NECK	☐	REFLEXES	☐	GLANDS
☐	CHEST	☐	GENITALIA		
☐	HEART	☐	BLOOD PRESSURE		
☐	ABDOMEN	☐	TEMPERATURE		

18. DETAILS OF POSITIVE FINDINGS, RELATION TO MILITARY SERVICE, AND WORKING DIAGNOSIS (L)

19. RECOMMEND THE FOLLOWING SERVICES: (CHECK) (M)

☐ MEDICAL TREATMENT — ESTIMATED NUMBER OF VISITS: OFFICE (R) HOME HOSPITAL

☐ SURGICAL CARE PROCEDURE (SPECIFY) (N) CODE NUMBER | ☐ X-RAY AND LAB (SPECIFY)* (S) CODE NUMBER

☐ SPECIAL SERVICE AND EXAMINATION (SPECIFY)* (O) CODE NUMBER | ☐ HOSPITALIZATION — ESTIMATED NO. DAYS (V)

SIGNATURE OF DOCTOR (P) | ADDRESS | DATE (T)

W.V.M.S.A. FORM NO. 100. (11) *PLEASE INSERT FEE SCHEDULE CODE NUMBER.

SUGGESTIONS FOR FILLING OUT FORM 100

V. A. Claim No. is absolutely essential for establishing service connection. This must be entered before this form is processed thru the agency. The medical records are filed by claim number. That is why they are so important.

ABSOLUTELY ESSENTIAL: If Claim No. is incorrect or missing the Service Serial No. may be used to complete the file for authority to treat. This number is more important than name, if veteran has filed claim.

Be careful of this one. It simply means—has a claim been filed for the *disability for which you are requesting treatment at this time.* If "No" is the answer and you wish this to serve as temporary claim, so state. V. A. may then approve temporary eligibility for treatment on this application. This is termed Prima Facie Eligibility.

Service dates must be shown because a vet. who has not served a total of three (3) months is ordinarily ineligible for benefits.

This one is necessary for establishing Prima Facie eligibility for treatment. State here only hospital or home care for the present ailments. If more space is needed use other side of Form 100. This means sick bay, ship hospital, in camp or V. A. hospital or any private hospital.

It is important that you enter here the date you (the veteran) requested medical care.

If Veteran is a student, is he covered by Public Law 16 or Law 346. Otherwise give name of occupation.

Describe here the patient's present day ailment.

Describe here in detail if possible the clinical history of the chief complaint. If the Veteran can describe how he contracted his ailment in service and the approximate time and place, it will help determine his eligibility. If he has been treated for this complaint while in service or after discharge, record this information here.

This is a report of your physical examination of your patient. This is a report of his "Chief Complaint."

State in your own words the details of your findings and their relation to the military service of your patient. Also define your working diagnosis.

Be sure all of your recommendations are based on your findings in Numbers 17 and 18.

If you recommend surgery check the Code No. in the fee schedule and write in the numbers that correspond with the type of surgery necessary. If more than one type of surgery is necessary be sure to describe each by its code number.

Most of the different types of medical care are covered by a code number. Use these code numbers whenever possible. If your patient's ailment is not listed in the fee schedule write it in by name and what you think is a fair fee. If you are recommending consultation give the name of the consultant.

If it is possible type in your name as well as signing it. It is very difficult to identify some names.

You will not receive authorization unless you ask for it. Write down the number of office, home or hospital calls you expect to make in the next 30 days. Be sure to include the original call in your request.

You must have authorization before you can do x-ray and lab. work. Request this work by code number. If you are *not* going to do this work in your own office—fill in the name of the vendor that is going to do it so authorization can go directly to him. If x-ray and lab. work is authorized you may order the work done and put it on your bill for payment.

This date is very important if you expect payment for services rendered. You must notify the Agency within 72 hours if the case is an emergency and you render necessary care. If the case is not emergent you have 15 days to notify the Agency. If the Form 100 will reach us within 72 hours that will take care of the emergency otherwise telephone or telegraph the Agency. *This date must agree with the date the veteran requested medical care.*

If you recommend hospitalization the name of the hospital, the approximate date of admission and the approximate number of days would be very helpful in speeding up authorizations. If you don't know these facts estimate the number of days of hospitalization and when you get authorization and you do hospitalize your patient, the burden is on you to notify the Agency within 72 hours of the name of the hospital and date of admission.

What About the Fee Schedule?

1. The fee schedule was agreed upon by the Veterans Administration and the State Medical Society as a maximum fee schedule to be charged for medical care for veterans with service-connected disabilities. The Veterans Administration is willing to pay the prevailing rate of fees up to the maximum fees set up in the fee schedule, but they do not want to be charged more for taking care of veterans than is charged by the physician for taking care of nonveterans. On the Form 200, an additional statement has been added to the certification to be made with each bill signed by the physician. The physician certifies that the fees charged for services rendered are not in excess of the fees charged by the physician for comparable services rendered nonveterans. By this procedure, the Veterans Administration is not establishing a higher fee schedule than the prevailing rate of fees charged in the different communities around the state.

When Does the Doctor Get Paid?

1. As soon as the Form 200 is returned to the agency by the doctor, the form is processed and put in a voucher and submitted to the Veterans Administration for payment. Our recent experience has been that the doctors are being paid within thirty days after the Form 200 is received in the agency. If the Form 200 is adequately filled out and does not have to be returned for correction, the doctor can expect payment from the agency within thirty days. With this new fee schedule, it will be necessary for each doctor to fill in his own fees for services rendered in the column provided on Form 200.

2. The Veterans Administration has a regulation that prevents any physician from earning more than $6,000 per year for services rendered to veterans. This can be acquired by part-time work with the Veterans Administration or on an entirely outpatient basis with the Veterans Administration.

What About Prescriptions?

1. Where the physician is prescribing medication, and if it is immediately needed, he may write for such medication or medical requisite by using his regular printed prescription blank which must bear the date written, the name and address of the patient, and the signature of the prescribing physician over the statement "I am authorized to treat and prescribe for the above named 'Veterans Administration patient'." (Statement of authorization may be written, typed, or stamped upon either side of the prescription blank). Prescriptions must be filled and dated by the pharmacy within ten days of the date written.

2. If, however, the prescription needs to be refilled or continuous medication reordered, wherever possible, the prescription should be sent to the Milwaukee Regional Office in order that the Veterans Administration might fill it and forward the medication to the patient. When the element of time is involved and, as stated above, where there should be no delay, the prescription should be filled locally. Where time will allow, it should be sent to the Regional Office of the Veterans Administration, 342 North Water Street, Milwaukee 2, Wisconsin. A patient should be instructed not to go to a druggist for refill of a prescription previously given. Each renewal of the prescription must be made by the physician. Otherwise, the druggist supplying the medication cannot be paid by the Veterans Administration.

What About Emergency Hospitalization?

1. In determining eligibility for treatment, physicians should attempt to determine from the patient whether he is a trainee under Public Law 16. If so, he is entitled to outpatient treatment for whatever the disability may be, although for hospitalization he cannot be hospitalized in a community hospital unless the condition is an emergent one. For other than very definite emergencies, he must be hospitalized in a Veterans Administration Hospital. Otherwise, the Veterans Administration will not be responsible for payment of hospital fees.

2. For hospitalization of service connected, Public Law 16, or female veterans, the closest Veterans Administration hospital suitable for care of a case should be contacted and arrangements made with them. Telephone call or telegram can be collect. The county service officer can very often arrange this. The contact representative of the Veterans Administration in that particular community can also arrange it as well as the physician treating the case. Veterans Administration hospitals are located at Tomah (neuropsychiatric cases), Waukesha (tuberculosis cases), Mendota (neuropsychiatric cases), Wood (all types of cases), and Minneapolis (all types of cases). The hospitals for neuropsychiatric and tuberculosis cases can also take general medical and surgical cases in an emergency.

3. When a veteran must be hospitalized immediately under circumstances involving an extreme emergency, it becomes the sole responsibility of the attending physician to notify either our agency or the Veterans Administration. Either telephone collect or send a wire. When you notify the agency, it is suggested that you try to have the following information about the veteran ready: his name, address, "C" or claim number if he has one, the name of the hospital, the date the veteran entered, and the ailment. This notice must reach either the agency office or a Veterans Administration office within seventy-two hours from the time the veteran enters the hospital. If the veteran is not receiving outpatient treatment at the time of the necessary hospitalization, the physician should complete Form 100 and forward it to the agency.

Form 200

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

350 WASHINGTON BUILDING • MADISON 3, WIS.

AUTHORIZATION TO TREAT AND BILL FOR SERVICES RENDERED

CLAIM NUMBER OF VETERAN: C-5 631 504

1. DOCTOR NO.	ATTENDING PHYSICIAN	2. VETERAN'S SURNAME	FIRST NAME	MID. NAME
1516	Dr. John Doe 541 W. Wisconsin Ave.	SMITH	John	J.
Mil	Milwaukee, Wisconsin	STREET ADDRESS OR P. O. BOX NO: 222 S. Herman St.		
Nov 121	R&PR 6060 (A)(1)	CITY: Milwaukee	STATE: Wisconsin	

3. THE ABOVE NAMED VETERAN HAS BEEN AUTHORIZED TO RECEIVE THE FOLLOWING TREATMENT BEGINNING 11-9-47 ENDING 12-8-47

1 Code No. 868 — 1 Code No. 0013 — Code No. ____

4 Code No. 891 — 12 Code No. 0014 — Code No. ____

Approved By:

4. The Veterans Administration diagnosis for this veteran is Bursitis, shoulder bilateral — Thos. J. Doran Director

5. COMPLAINT OF PATIENT (1)

Pain in Shoulder

6. PHYSICAL FINDINGS

Bursitis Calcaire of right Shoulder

7. TREATMENT AND PROGRESS

Radiotherapy treatments X-ray therapy. Improved

8. DIAGNOSIS

Chronic sub-Acromial bursitis

9. TREATMENT RECORD. I certify that treatment was rendered the above named veteran beginning 11-9-47 and ending 12-8-47 as follows, and that payment in whole or in part has not been received and that the fees charged by me are not in excess of the fees charged for comparable services rendered non-veterans.

10 ENTER NO OF CALLS UNDER DAY OF MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Enter your fee	DO NOT USE THIS SPACE
FIRST OFFICE VISIT									X																							3.50	
REPEAT OFFICE VISIT	X		X			X		X				X		X			X		X			X				X		X		X		30.00	
HOME DAY—BEFORE 10 P. M.																																	
HOME NIGHT—AFTER 10 P. M.																																	
HOSPITAL VISIT																																	

11. SURGICAL PROCEDURES AND DATES PERFORMED

12. NATURE OF SPECIAL SERVICES DATE PERFORMED

891 X-ray therapy 11-10, 11-15, 11-20, 11-25 — 20.00

13. LIST OF X-RAY AND LAB SERVICES PERFORMED IN YOUR OWN OFFICE DATES PERFORMED

868 X-ray R. Shoulder 11-9-47 — 10.00

REPORT MUST BE ATTACHED TO THIS BILL

14. LIST OF X RAY AND LAB SERVICES SENT OUT—GIVE NAME OF DOCTOR TO WHOM REFERRED. DATES PERFORMED

REPORT MUST BE ATTACHED TO THIS BILL

15. PATIENT'S PRESENT CONDITION (STATIONARY) (PROGRESSIVE) (IMPROVED)

I RECOMMEND FOR THE NEXT 30 DAYS: effective December 9, 1947 (Starting Date)

☐ NO FURTHER TREATMENT INDICATED

☒ FURTHER TREATMENT REQUIRED. ESTIMATE BELOW:

☐ HOSPITALIZATION DAYS: ____

☐ MEDICAL TREATMENT. SPECIFY BY CODE NUMBER AND AMOUNT OF TREATMENT

TOTAL 63.50

CODE NO 891 HOW MANY 4 | CODE NO ____ HOW MANY ____

CODE NO 0014 HOW MANY 12 | CODE NO. ____ HOW MANY ____

REMARKS ____

SIGNED John Doe M. D.
SIGNATURE MUST BE IN INK

ADDRESS 541 W. Wisc. Ave. Milw. Wis.

(1) Please elaborate on significant findings of: history, physical signs, and special procedures.

Date of Authorization

$ ____ DATE ____ CHECK NO ____ VOUCHER NO ____

INSTRUCTIONS: Forward first 4 copies to Wisconsin Veterans Medical Service Agency, 350 Washington Building, Madison 3, Wis. Keep 5th copy for own files. Form to be made in quintuplicate.

W. V. M. S. A. FORM 200 7-47-K

Suggestions For Filling Out Form 200

Lines 1, 2, 3, and 4 will be filled in by the agency according to authorization received from the Veterans Administration. Specified period of treatment is entered in line 3, and work authorized should be done during that period. If, when you receive authorization to treat a veteran, you find you need more authorization for this period, contact this agency or the Veterans Administration by letter immediately requesting authorization.

Line 4 is the Veterans Administration diagnosis for this veteran, and authority is given to treat the veteran for that diagnosis.

Lines 5, 6, 7, and 8 will be completed by the doctor according to his findings.

Line 9 is a statement by the doctor, and beginning and ending dates should be the same as dates entered on line 3.

Lines 10 through 14 is your bill for services rendered a veteran. The treatment chart should be completed by entering "X" under each day of the month that office visits, day and night home visits, and hospital visits were taken.

Enter on line 11 the code number, date, and name of surgical procedures performed.

On line 12 list the code number, date, and name of special services performed, such as, "X-ray therapy #891, (date)."

Line 13 should include code number, name, and date of laboratory services and x-rays performed in the doctor's office.

Line 14 should include code number, name, and date of laboratory services and x-rays sent out, giving name of hospital or doctor to whom referred.

Line 15 is your request for further treatment for the next thirty days effective on date of next treatment. The Form 200 should be forwarded to this office immediately after completion of treatment so that we may forward your request for further treatment to the Veterans Administration. Your request for continued treatment must reach this agency within fifteen days from the expiration date on Form 200.

Form 200 must be signed by the doctor to whom the form is addressed. Signature must be in ink.

In cases in which more than one visit is taken within a twenty-four hour period, please make a brief explanation of the circumstances.

Authorization for treatment cannot be set up by this agency or the Veterans Administration unless you request it, as the agency does not know how you want to treat your veteran, so please request the number and type of treatments by code number that you will need.

FEDERAL TAX DEDUCTIONS FOR MEDICAL CARE

Medical, dental, drug, nursing, hospital, and related expenses which are in excess of 5 per cent of the taxpayer's adjusted gross income, may be deducted if *actually paid* during a given year. The cost of hospitalization, health and accident insurance may be included in such deduction, as may travel where directly related to hospitalization, recuperation, and the travel expenses of a minor child and parent, which are directly related to hospitalization and medical care. The maximum deduction where there is a single surtax exemption is $1,250; if there are two or more surtax exemptions, the maximum allowance for medical expenses is $2,500. If any of the above expenses are compensated for by insurance or otherwise, they are not to be included in the total.

The expense must be for the medical care of the taxpayer, his spouse, or a dependent. Taxpayers are required to furnish the name and address of each person to whom such expenses were paid, and the amount and approximate date of payment. Where a joint return is filed, the 5 per cent limitation is computed on the aggregate adjusted gross income of husband and wife. Payments for waiver of premiums on a life insurance policy are *not* includable as medical expense.

Your National Service Life Insurance

Its Provisions, Value, and Future Changes

IN CONNECTION with military service, the matter of insurance has been of concern to many Wisconsin physicians. Those holding National Service Life Insurance are often concerned with the advisability of retaining this type of insurance after return to civilian practice. For the benefit of all veteran members the subject of National Service Life Insurance is summarized below.

NATIONAL SERVICE LIFE INSURANCE

Introduction

To provide life insurance in amounts from $1,000 to $10,000 for persons in the active service of the armed forces of the United States there was enacted a statute known as the "National Service Life Insurance Act of 1940." This was in anticipation of the perils incident to service in our armed forces either under the Selective Service Act or during a state of actual war, it being appreciated it would be impossible for men in service to procure adequate life insurance from private carriers except at extremely high rates. As amended in 1946, a total disability income provision was added to National Service Life Insurance authorizing a disability income of $5 per month per thousand dollars of insurance carried, commencing with the seventh month of total disability. The benefit may be added as a rider at a small additional cost to any of the seven types of policies now available. A physical examination is required upon application for the benefit to prove good health. It may be applied for at any time prior to the policyholder's sixtieth birthday. The monthly payment will commence with the seventh month of disability and will continue during the period of total disability with no deduction from the face value of the policy.

It also provides that payment of premiums is waived during the continued total disability of a service man which began subsequent to the effective date of his insurance, and which continued for six consecutive months or more, having commenced prior to the insured's sixtieth birthday.

Persons Insurable

Any person in active service in the land or naval services of the United States, including the Coast Guard, is entitled to apply for national life insurance if such person is serving under orders to active duty not limited to a period of less than thirty-one days.

As amended in 1946, all persons who were in the active service between October 8, 1940 and September 2, 1945, *even though they had not previously applied* for National Service Life Insurance, may be granted insurance on the five-year level premium term plan in an amount of not more than $10,000 nor less than $1,000, in multiples of $500, upon proof of good health and other requirements outlined in the original act. If the application is made prior to January 1, 1950, it will not be denied because of a disability, less than total in degree, proved to have resulted from active service.

If insurance has been allowed to lapse, or was not contracted for while the veteran was in the service, he would be wise to take advantage immediately of this benefit while it is available. National Service Life Insurance is considerably cheaper than a comparable civilian policy and is one of the most valuable privileges offered the serviceman.

Beneficiaries

Public Law 589, 79th Congress, approved August 1, 1946, provided that the insured shall have the right to designate as beneficiary any person or persons, firm, corporation or other legal entity. If the insurance matured prior to August 1, 1946, beneficiaries shall be restricted to members of the insured's immediate family. The above change does not mean, however, that the policy may be assigned as security for a debt. This is not permitted.

The veteran carrying national service life insurance has the right at all times to change the beneficiary or beneficiaries without the consent of the latter. Under the act the beneficiary has no vested or property rights in the proceeds of the insurance, even under a contract whereby the insured agrees not to change the beneficiary.

Cost and Conversion of Service Insurance

Seven types of National Service Life Insurance are now available to the serviceman or the veteran. He may continue to carry the same level premium term insurance he had in the service for a period of eight years from the original policy date if this was before January 1, 1946. If issued after this date, the policy may be continued for five years. At the end of either time the policy must have been converted to a permanent plan of insurance or dropped. This deadline will be about the year 1950 for the average veteran. The six permanent-type plans are: Ordinary Life; 30-Pay Life; 20-Pay Life; Endowment at 65; Endowment at 60; and 20-Year Endowment. The cost of the above insurance will average between 20 per cent and 30 per cent cheaper than comparable civilian policies as there is no charge for administrative expense. The total cost to the serviceman may be further reduced if he converts

as of the original effective policy date, or if he prepays his premiums in advance at a discount, either quarterly, semiannually, or annually.

The cash reserve on the veteran's policy will draw interest at the rate of 3 per cent. Earnings of the Insurance Fund in Washington, in excess of 3 per cent, and savings as a result of a lower than anticipated mortality rate, will be paid to the holder of permanent plan policies as dividends. These dividends compared favorably after the last war with comparable civilian policies.

The type of policy converted to will depend on the circumstances of the individual. In general, however, it is possible to say that the three life insurance plans provide more protection for the amount of premiums paid in than do the endowment policies. However, the endowments having a greater cash reserve due to the larger premiums accrue a greater amount of interest and thereby provide at low cost old age income or retirement policies. Your nearest Veterans Administration will be glad to assist you in converting your insurance.

Except for term insurance, National Service Life Insurance policies provide cash, loan, paid-up, and extended insurance values just as do all types of permanent life insurance. There are no restrictions as to the occupation of the insured. No aviation clause is included, nor does it make any difference where the insured lives. The proceeds of the policy cannot be attached by creditors, and are free from taxation, except for inheritance tax purposes.

Grace Period

A grace period of thirty one days, during which the insurance will remain in effect, is granted after the due date of any premium. Should the thirty-first day fall on a Sunday or holiday, the grace period will be extended for one day. This seems like a small point, yet it has proved very important to beneficiaries of several Wisconsin veterans. If the premium is paid within the grace period, the policy does not lapse but continues as long as timely remittances are submitted to the V. A.

Payment of Benefits

Four optional modes of settlement are now available to the insured under provision of amendments effective August 1, 1946. Option I provides for lump-sum or cash settlement upon the death of the insured, provided this settlement plan was selected by him and properly recorded. Selection of this option becomes valid when notice thereof is received by the Veterans Administration. If the insured has selected Option I, the beneficiary may elect to receive payment under Option II, III, or IV instead.

Option II provides for equal monthly payments over a period of from three to twenty years as selected by the insured, or the beneficiary in event no selection had previously been made. In the event a choice was made by the insured the beneficiary may select a settlement over a longer period of time. Monthly payments vary between $28.99 per month per $1,000 of insurance for a three year period, and $5.51 per month per $1,000 of insurance for the twenty-year period.

Options III and IV provide for payment of benefits during the life of the beneficiary, with certain minimum settlements guaranteed in event of the beneficiary's death prior to certain times.

In the event that no selection is made by either the insured or the beneficiary, the insurance benefits will automatically be paid in 36 equal monthly installments.

Due to the removal of beneficiary restrictions there is no longer a "permitted class" who receive settlement in the order of their relationship in the event no selections were made by the insured. It is therefore imperative that the insured now make a complete selection of his primary and successive beneficiaries and properly submit it to the Veterans Administration.

To Hold, Convert, Reinstate, or Drop?

In the November 20, 1945, issue of "New York Medicine" a short article on National Service Life Insurance was directed to physicians who might come in contact with servicemen who questioned the advisability of continuing their payments of premiums. The advice is likewise applicable to physicians themselves. We quote:

"1. National Service Life Insurance is a participating contract with a lower gross premium than issued by private companies.

2. There is no loading for expense of administration, acquisition, etc., since this charge is borne by the taxpayers.

3. Conversion may be exercised without evidence of insurability.

4. Non-forfeiture provisions are higher than private companies since the contract does not contain a surrender charge.

5. Waiver of premium benefits is included without extra charge and the phraseology of this clause is much more liberal than will be found in private company contracts. Also, the interpretation of this clause is more liberal.

6. The contract contains no restrictions as to residence, travel, aviation or war.

7. Proceeds are completely tax free and creditor proof."

If the term insurance carried in the service has been allowed to lapse, it is possible to reinstate it prior to July 31, 1948, without a physical examination. This act necessitates completion of the proper form, to be secured from the local Veterans Administration office, containing a statement that the applicant is in as good health as when the insurance lapsed, and a tender of two monthly premiums. It will not be necessary to remit premiums for the months the term insurance was not in force. Such reinstatement will be possible only within eight years from the time the insurance originally be-

came effective, provided it was contracted for prior to January 1, 1946, or within five years if the original effective date were after January 1, 1946.

It is of the utmost importance that the veteran continue to pay his premiums by check, draft or money order, payable to the Treasurer of the United States, even though he does not hear from the Administration. The fact that he may not receive a premium receipt or premium notice does not relieve him of the responsibility of keeping his insurance in force by remitting his check.

Low Cost

The February 23, 1946 issue of the *Saturday Evening Post* stated: "For a veteran of 25, the NSLI premium is 23 per cent lower for ordinary life insurance than the figure you obtain if you average the premiums charged by the ten leading mutual companies . . . Again taking the average of ten leading private companies, NSLI income (to a beneficiary) is 30 to 35 per cent bigger." Even at that time it was a bargain unequaled by any civilian company. Now, with the amended legislation of August 1, 1946, it has become probably the veteran's most valuable, but least appreciated, benefit. The single drawback of the insurance is, at present, the slow and confusing service offered in comparison to the businesslike efficiency of civilian companies. Time alone will correct this.

Where to Write

In writing to the Veterans Administration about N.S.L.I., or in submitting insurance premiums, a veteran should always write his policy number, if he has it, on his letter or check. His service serial number should also be shown. The address of the V. A. branch office serving Wisconsin, Indiana, and Illinois veterans for insurance purposes is V. A. Branch Office No. 7, Insurance Service, 615 West Van Buren Street, Chicago 7, Illinois.

Loans and Grants For Veteran Doctors*

SECTION 45.35 of the Wisconsin Statutes authorizes the Department of Veterans Affairs to make loans for education, rehabilitation, or the purchase of a property or business to veterans of World War II who meet the basic eligibility requirements of Wisconsin law. Thus the physician who needs new equipment for his office, an automobile to be used in his practice, or help in purchasing or improving a home, may borrow up to $1,000 at 2 per cent simple interest. Loans are amortized on a monthly basis, and the initial period on all loans is one year with the privilege of four renewals of one year each if commitments are met as they come due. The loan privilege may not be used as a refinancing facility unless the applicant's property is in jeopardy because of garnishment, attachment, etc. In the latter instance, loans may be made for the consolidation of debts. Loans made by the Department of Veterans Affairs must ordinarily be secured by mortgage, collateral, or acceptable endorsements. Character loans are made in certain special circumstances.

Veterans who have enrolled in school under the auspices of the federal Veterans Administration sometimes experience delay in receiving their first or succeeding federal subsistence checks. Loans will be made to these people on signature and are repayable upon receipt of the benefit for the period from the federal government. This repayment plan does not impose a hardship on the veteran because, though the initial federal check may be delayed, he ultimately receives a lump sum payment to bring his account up to date.

Loan applications should be filed through the County Veterans Service Office in the veteran's home county. The application will be reviewed by the local County Veterans Loan Committee and forwarded by the Committee to the Department of Veterans Affairs for disposition.

Beneficiaries of loans or grants under the Wisconsin law must retain their residence in the state during the period of receipt of benefits. Grants will not be made for educational courses in schools outside of the state if the same instruction is available within Wisconsin. This restriction does not, of course, apply to highly specialized courses, but a special determination will be made in each individual case based upon the recommendation of qualified advisers.

Basic eligibility requirements for benefits from the Postwar Rehabilitation Trust Fund are given in Section 45.35 (5a) of the Wisconsin Statutes as follows:

> "Veteran" as used in this section means any person who served in the active military or naval service of the United States at any time between August 27, 1940 and July 25, 1947 who was honorably discharged therefrom, or who served under honorable conditions, after 90 days or more of active service, or if having served

* Prepared for the *Journal* by Gordon A. Huseby, Director, Wisconsin Department of Veterans Affairs.

less than 90 days was honorably discharged for disability incurred in line of duty, who has been a resident of this state for at least 5 years next preceding his application or a resident of this state at the time of his enlistment or induction into service and such resident at the time of making application and, in all cases, who continues his residence in this state during the full period of the rehabilitation.

It is probable that numerous Wisconsin physicians will want to make some use of the educational benefits available to them by reason of their military service. Many, no doubt, wish to continue studies in which they were engaged when activated into the armed services, and others will want to take refresher courses before resuming private practice. Some will use their educational entitlement in preparing for practice in one of the specialist fields. To all of these the Wisconsin program of veteran rehabilitation offers substantial assistance under qualifying circumstances in the form of educational grants or loans together with economic grants and loans to assist them in the establishment or revival of their private practice.

Physicians recently released or about to be released from service may find it extremely difficult from a financial viewpoint to delay opening their offices for periods of several weeks or months. For many it would be utterly impossible, particularly the man with heavy family responsibilities, if his only income were the nominal subsistence allowance provided by either the G. I. Bill or Public Law 16, the vocational handicap bill.

The Wisconsin Department of Veterans Affairs, has liberalized the educational grant policy of the department considerably, affording a new opportunity for further study to men who might otherwise be denied a chance to use their federal educational benefit. Applicants who are otherwise eligible, who are enrolled in courses of instruction under either federal Public Law 346 or 16, may now be awarded supplementary educational grants by the Wisconsin Department of Veterans Affairs depending on their circumstances and family situation. While the Wisconsin statute does not contemplate a bonus or annuity and specifies that grants may be made only to prevent or alleviate "want and distress," the law directs a liberal interpretation of this qualification, and the board has translated the legislative mandate into a realistic policy which guarantees sympathetic consideration for every application submitted.

Emergency grants are also available to the student for the benefit of himself or his dependents in unforeseen contingencies. The board recognizes that concern over his dependents' welfare may handicap the student veteran and has made liberal provision to cushion the shock of any emergent situation that might arise during the adjustment period.

Members of the medical profession and others are invited to address the Director, Wisconsin Department of Veterans Affairs, State Capitol, Madison 2, Wisconsin, for further information. County veterans service officers, the service officers of veterans' organizations, and local chapters of the American Red Cross are also prepared to assist veterans with applications.

PHYSICIANS AND THE PHARMACY LAW

The sale, compounding and dispensing of drugs, other than narcotics, are governed by the provisions of chapter 151, Wisconsin statutes, entitled "Pharmacy." This defines the practice of pharmacy and sets forth the requirements of registration and other regulations of those who practice in this field.

The definition of "drugs" is very broad. Included are all articles intended for use in the diagnosis, cure, mitigation, treatment and prevention of disease, together with articles recognized in the official pharmacopoeias.

It is expressly provided in section 151.04 (3) that this chapter shall not interfere with the dispensing of drugs, medicines or other articles by physicians. The effect of this provision is that physicians are not governed by this law in so far as they dispense or compound drugs for their own patients or fill an occasional prescription for another physician. However, they must not fill prescriptions for others *as a business.* See 3 Atty. Gen. 555; 16 Atty. Gen. 722. A physician who desires to engage in the business of pharmacy must comply with the provisions of the pharmacy law just as must the pharmacist.

This chapter of the statutes has nothing to do with narcotic drugs, their definition or use. For information on this field see "Narcotic Laws," page 84.

Access to Hospital Records*

Some Legal Aspects

A PERPLEXING problem which confronts hospital administrators is the determination of a proper policy with respect to access to hospital records. What about permitting inspection of or furnishing or permitting the making of copies of hospital records of a patient? What should be commonly recognized as the ethical obligations of the hospital to its patients? The hospital occupies a confidential position with respect to its patients analogous to that occupied by the attending physician. It would be illogical for the physician to be bound professionally to keep inviolate information acquired in his professional capacity and yet to permit the same information, reduced to the case record of the patient, to be disseminated indiscriminately. The proper approach, it would seem, is not to determine the question in the light of what liability, if any, is assumed by the hospital in permitting access to the records of a particular patient but rather to view the matter in the light of what duty, if any—legal, ethical, or moral—there is on the hospital to permit access in any particular case. Few decisions, of courts of appellate jurisdiction—usually the only courts whose decisions are available in the published reports—can be found that are squarely in point for the purpose of the present discussion. General principles, then, seem to be the only basis from which to carry on the discussion.

On principle, it would seem that a hospital retains case records for a twofold purpose: (1) It retains them as a trustee, or in some other confidential capacity, for the patient and the attending physician and (2) it retains them as evidence of the care and attention its own servants rendered in the case. If, then, a hospital retains case records as a trustee or in some other confidential capacity for the patient and his attending physician, in theory it can make no use of those records except, of course, in defending itself from charges of negligence inconsistent with the rights and interest of the patient and the attending physician. Strictly from the patient's point of view he is entitled to privacy; that is, he has the right that the nature and incidents of his illness be not subjected to public view but only to the view of those who are acting for him and in his interest.

This general rule may be altered possibly in any particular instance by the presence of (1) some specific local law or ordinance on the matter, (2) some express contract between the hospital and the other interested parties or (3) some express hospital regulation or possibly local custom on the subject, concerning which the patient and the attending physician had actual or implied knowledge.

There must necessarily be excepted from any extended discussion instances in which any of the qualifying factors just noted are present. Obviously a general statement with respect to such situations is impossible because of unpredictable factual setups. For instance, we cannot anticipate the exact wording of a state statute or a local ordinance with respect to a governmental hospital that would permit general access to the records concerned. Nor can we hypothecate a discussion on conceivable hospital regulations or local customs with respect to the matter; furthermore, if there is an express contract entered into between the hospital, the patient and the attending physician with respect to the future use of the records concerned, the terms of that agreement, of course, will govern.

Of the qualifying factors mentioned, the most common will be instances in which some state statutes or local ordinance in specific language denominates the records of a governmental hospital as public records. The very concept of a public record implies generally a right on the part of the public to inspect on demand. Even if there is such a statute or enactment relating to a particular governmental hospital, however, it must not be assumed that any person is legally entitled to access to the complete records of that hospital. There may be reason to draw some distinction between the right of the public to view the records maintained for or relating to administrative purposes and the public right to view that portion of the record maintained for pathologic purposes, the clinical records. Furthermore, even if there is an enactment of this type, if there is also a statute prohibiting physicians from disclosing in court information acquired in attending a patient, it is quite generally held that a governmental hospital cannot be compelled to grant access to its records to a third person (*Massachusetts Mutual Life Ins. Co. v. Board of Trustees of Michigan Asylum for the Insane* (Mich.). 144 N. W. 538) and that such records if subpenaed in court are not admissible in evidence over the patient's objection. (*Davis v. Knights of Honor* (N. Y.), 58 N. E. 891; *Soverign Camp v. Grandon* (Neb.) 89 N. W. 448; *Smart v. Kansas City* (Mo.), 105 S. W. 709.)

Coming then to the more common situation in which there is no law or enactment requiring a hospital to grant access to its records, nor any express contract relating to the matter; nor any hospital regulation or local custom that might govern the matter of access. Under such circumstances there seem to be no legal grounds on which it might be contended that any person, except possibly the patient or his attending physician, has a right of access to the records, unless by virtue of a subpena where those records are presented in court or before some administrative tribunal. The only persons, it

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would seem, who can be said to have any legal right of access to a particular case record are the patient, his attending physician or some one designated by the patient to act in his interest. It is not altogether clear that even the patient has a legal right to such access, but in view of the fact that the hospital in its compilation and custody of the record of a particular patient is acting as a trustee, in part, for the patient, the patient's interest should govern the hospital's conduct, and the primary question should not be Has the patient an enforceable legal right to inspect the records? but rather What good reason is there for denying his access? The patient may have an immediate interest in such records, either with a view to litigation or with a view to subsequent treatment: to that extent he may be harmed by a refusal to permit him or his representatives to inspect or copy the records. On the other hand, if the records have been properly kept and the case properly treated, neither the hospital nor the attending physician has any real interest in denying access. In any event, if litigation occurs, the production of the records in court or before some tribunal can be compelled.

In many instances an attending physician may desire access to records with respect to a previous hospitalization of his patient during which the patient had another attending physician. In such an instance it would seem that access should be granted to the present attending physician; clearly so when the patient authorizes the hospital to do so. Even in the absence of such express authorization by the patient, access should be granted on the theory that when a patient places himself under the care of a physician he authorizes that physician to use such measures as are necessary to diagnose his condition and to determine and pursue the proper course of treatment, and obviously the records with respect to a previous hospitalization may often be of material aid to the attending physician. If a patient specifically objects to his attending physician viewing the record, the safest course for the hospital would seem to be to act in accordance with the patient's wishes.

Thus far I have discussed what seems to be the proper policy when the patient or some one acting in his interest seeks access to the records. What then should be done when access is requested or demanded by persons other than the patient or his representatives? A hospital is under no obligation to permit any one, save possibly the patient, his representatives and the attending physician, to examine or copy records of a given patient unless such examination is required by a valid statute, ordinance, regulation or an appropriate court order. For the protection of the hospital, evidence of proper authority from the patient should be required of every one, other than the patient and the attending physician, who desires access to the records in a given case, before permitting an examination of such records. Claim agents, attorneys and representatives of insurance companies, unless accompanied by the patient, should be required to present written authority from the patient before access is allowed.

Probably the most frequent request or demand for access to hospital records comes from representatives of insurance companies. An insurance company is not entitled to such access even though it has insured the life, limb or health of a patient. This is true even though the insurance policy involved requires the patient to furnish the information the insurer seeks, for even then the insurer should seek such information from the patient and not from the hospital. Although a contract of insurance contains express or implied authority for a hospital to give out such information, the hospital is not a party to the contract and cannot safely accede to what appears in the policy to be the patient's consent to access. It is a safer practice to require, as a condition precedent to access, the written consent of the patient, dated as nearly as possible to the date access is desired. If the patient refuses to sign a consent at that time or refuses to obtain the desired information for the insurance company, certainly the hospital has no right to do so on its own account.

Cases may arise that require a hospital to deviate from the rules that have been stated and to assume the responsibility of giving information without the consent of the patient, as where the patient is unconscious, delirious or seriously ill so that he himself cannot supply the information but the information is essential to the procuring of some immediate benefit to the patient or to those dependent on him. The proper officer of the hospital may then assume the responsibility, recognizing it as a responsibility; but, generally speaking, in such a case the law would presume the consent of the patient as to what is definitely for his benefit.

Finally, the question often arises as to the right of a hospital either to lend its hospital charts for research work or to use them in staff conferences or other clinical study. Whether the patient's right to privacy should yield to some extent to the cause of medical science, I am not prepared to say, as no legal authority can be found that would permit a hospital to make such use of its case records. The universality of the custom among hospitals in permitting such use of its case records may or may not have a bearing on the question. In any event, the least the hospital can do is to require the consent of the attending physician and to insist that the case records be used and presented in such a way as not to reveal the identity of the patient or of the attending physician.

Of course, nothing that has been said here has reference to the making of reports required by law. Where the law requires a report to be made of a birth, of a communicable or industrial disease, of a crime or of a death, that report must be made, and the law will protect the maker. Such a legal requirement would also doubtlessly protect a hospital in the making of most, if not all, of the reports required by workmen's compensation acts.

This discussion, as noted earlier, has dealt with the right of a demandant to secure access to the

hospital records of a particular patient, and no discussion has been given to the liability of a hospital for making an improper, unauthorized disclosure. Conceivably such a liability could be imposed on a hospital, though no case is known in which a court has held a hospital liable for damages for the unauthorized disclosure of hospital records.

In conclusion, the procedure followed in permitting access to a patient's record should conform to the standards of conduct which physicians have prescribed for themselves with respect to the sanctity of confidential communications. A patient cannot well be denied the privilege of access to his own records, nor may this privilege be denied his attending physician, his attorney or any other person acting with his authorization and in his interest. Furthermore, such access should not also be dependent on the written consent of the attending physician. No other person should be accorded access to the records, however, without the patient's written permission, and this rule should be rigidly enforced as against claim agents, insurance adjusters and attorneys. Any other policy would certainly serve no useful purpose for the hospital.

The accompanying form to evidence the patient's consent to access to the hospital records by a particular person is submitted for consideration. Certainly, if the execution of such a consent is required before access is permitted and if the executed form is presented by the hospital, the hospital is in a formidable position as against any potential liability to its patient, and, in following the procedure just suggested, could also rest secure in the knowledge that its actions had been in accord with the highest medical ethics.

Consent to Access to Hospital Records

To_____[insert name of hospital superintendent] _____hospital

I) hereby authorize and request you to furnish
We)

a copy of the hospital records of _____ [insert name of patient] or to allow those records to be inspected by_____[insert name of grantee].

I) hereby release_____hospital and
We)

you personally from all legal responsibility or liability that may arise from the act

I) have authorized above.
We)

Signature of patient_____

Other signatures_____

_____

Date_____

Witness_____

NOTE.—The signature of the patient alone should be sufficient in all cases except when the patient is a minor or is incompetent, in which cases, in addition to the patient's signature, the signature of the parents or surviving parent or guardian, respectively, should be obtained.

Explanation.—This form when duly executed should be attached to the hospital records of the patient, with a notation as to the date on which the records were viewed or copy was furnished.

No particular form is suggested for a patient's request to be furnished a copy of or to be allowed to inspect his own records. Such a request, however, should be in writing and should be attached to the records with the notations indicated just above.

A. M. A. MEMBERSHIP AND FELLOWSHIP DEFINED

Every MEMBER in good standing in the constituent medical association of the state in which he is engaged in practice whose name is officially reported to the Secretary of the American Medical Association for enrolment becomes automatically a MEMBER of the American Medical Association and is not called on, as such, to pay any dues or to contribute financially to the Association.

MEMBERS of the American Medical Association who graduated at recognized medical schools are eligible to apply for FELLOWSHIP.

To qualify as a FELLOW, a MEMBER in good standing is required to make formal application for FELLOWSHIP, to pay FELLOWSHIP dues and to subscribe for *The Journal.* Applications must be approved by the Judicial Council. Fellowship dues and subscription to *The Journal* are both included in the one annual payment of $12.00, which is the cost of *The Journal* to subscribers who are not FELLOWS.

Only those MEMBERS who qualify as FELLOWS are eligible for election as officers, may serve as members of the House of Delegates, may register at the annual sessions of the Association or may participate in the work of its scientific sections.

MEMBERS of constituent state medical associations pay dues to those bodies, but as MEMBERS they pay nothing to the American Medical Association. FELLOWS pay dues and subscription to *The Journal* in the sum of $12.00 a year, which has nothing to do with county or state dues.

According to an amendment to the By-Laws of the American Medical Association, no physician may be officially recorded as a MEMBER OF the American Medical Association except on the basis of membership in *one* constituent state medical association and that one the association of the state in which the physician concerned maintains legal residence and engages in the practice of medicine.

Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $8.50 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full burden.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on a $10.50 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $10.50 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wis-

consin General Hospital. Crippled Children's Division secures admission for many patients through its services.

Bradley Memorial Hospital: This is the psychiatric unit of the Wisconsin General Hospital and not a separate unit.

University of Wisconsin Infirmary: Student health center and hospital.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

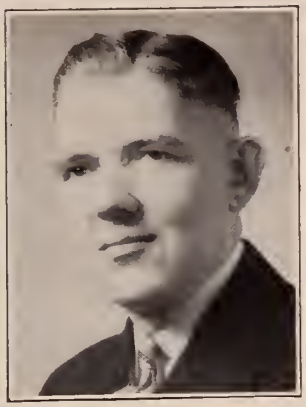
IDENTIFICATION BY BLOOD TEST

Of interest to physicians is the restriction placed upon the use of blood tests taken for the purpose of determining the paternity of a child. In criminal bastardy proceedings the results of the tests are admissible to prove only that the defendant is *not* the father of the child, and results which show only that the defendant might be the father are not admissible. Such tests, in a criminal action, are conducted by a physician or other duly qualified persons who are appointed by the court and paid by the county (Section 166.105 Wisconsin Statutes, 1945).

In a civil action the court may direct any of the persons involved to submit to a blood test for purpose of establishing identity or parentage. Here again, only if definite exclusion of the person is established may the results of the tests be received in evidence (Section 325.23 Wisconsin Statutes, 1945).

State Board of Health, Services, Laws, and Rulings

C. N. NEUPERT
State Health Officer



E. H. JORRIS
Assistant State Health Officer

District Health Offices

THE state has been divided into nine districts by the State Board of Health with a full time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer and secretary make up the staff in each office. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing or sanitation. Due to the loss of personnel as a result of the war, it has been necessary to combine districts. A list of the district health offices, medical director and the counties included in each district follows:

District Office No. 1—Beaver Building, Madison

Health Officer: Dr. A. V. de Veneu

Counties included: Crawford, Richland, Sauk, Columbia, Dane, Green, Lafayette, Iowa and Grant

District Office No. 2—Municipal Bldg., Elkhorn

Health Officer: Dr. Elmer E. Bertolaet

Counties included: Jefferson, Rock, Waukesha, Walworth, Milwaukee, Kenosha and Racine

District Office No. 3—Court House, Fond du Lac

Health Officer: (Vacancy)

Counties included: Winnebago, Sheboygan, Calumet, Dodge, Manitowoc, Washington, Fond du Lac and Ozaukee

District Office No. 4—City Hall, Sparta

Health Officer: (Vacancy)

Counties included: La Crosse, Waushara, Green Lake, Monroe, Juneau, Vernon, Adams and Marquette

District Office No. 5—City Hall, Wisconsin Rapids

Health Officer: (Vacancy)

Counties included: Pepin, Clark, Buffalo, Wood, Trempealeau, Marathon, Jackson and Portage

District Office No. 6—City Hall Annex, Green Bay

Health Officer: (Vacancy)

Counties included: Waupaca, Kewaunee, Shawano, Door, Oconto, Brown, Marinette and Outagamie

District Office No. 7—Box 36, Chippewa Falls

Health Officer: Dr. Chester C. Burski

Counties included: Polk, Dunn, Barron, Rusk, Chippewa, Pierce, St. Croix and Eau Claire

District Office No. 8—P. O. Box 269, Rhinelander

Health Officer: Dr. Francis Cline

Counties included: Taylor, Price, Lincoln, Oneida, Forest, Vilas, Florence and Langlade

District Office No. 9—Vaughn Library Building, Ashland

Health Officer: Dr. Margaret Hatfield

Counties included: Douglas, Bayfield, Burnett, Washburn, Ashland, Sawyer and Iron

Communicable Diseases

Quarantinable diseases.—Cerebrospinal meningitis (epidemic), cholera (Asiatic), diphtheria, plague, scarlet fever, smallpox, typhus fever, yellow fever.

Placardable diseases.—Chickenpox, infantile paralysis, influenza, leprosy, measles, German measles, typhoid fever, whooping cough.

Reportable only.—Amebic dysentery, epidemic septic sore throat, erysipelas, infectious encephalitis, malaria, mumps, ophthalmia neonatorum, pneumonia (lobar), trachoma, tuberculosis, tularemia and undulant fever.

Reporting of cases.—A physician is required to report to the health officer within twenty-four hours all cases of communicable disease. Sec. 143.04 (All suspected cases must be reported and considered as positive until a correct diagnosis can be made. Any neglect or refusal of a physician or householder to report cases of communicable disease makes him liable to a severe fine.)

Privilege under quarantine.—Physicians are among the few individuals specified by law as permitted to enter premises quarantined for communicable disease. The expense of maintaining quarantine, including examinations and tests for disease

carriers, provided this is done under direction of the local board of health, and the enforcement of isolation, shall be paid by the town, village or city, but the expense in treating communicable disease is not an obligation of the local board of health, and the local authorities cannot be held liable unless prior arrangement has been made with the physician. Sec. 143.05.

Vaccination for smallpox.—When vaccination or exclusion from school is ordered because of the appearance of a case of smallpox in the community, the local board of health shall provide for the free vaccination of the children of the municipality at municipal expense. Sec. 143.13(3). Parents may employ physicians of their own choice to perform vaccination of their own children but must pay the expenses incurred.

Venereal disease.—All physicians and certain institutions are required to report directly to the State Board of Health all persons with venereal disease in a communicable state who come to them for treatment. Sec. 143.07.

A printed form, serially numbered, furnished by the State Board of Health, is used for reporting. Printed instructions for the patient are attached to this report blank and are required to be given to him. Secrecy is imposed upon the State Board. Sec. 143.07.

The State Board of Health requires that the source of infection be investigated and reported back to the Board for the purpose of investigation. All persons having a venereal disease must remain under treatment until the disease is no longer communicable. Discontinuing treatment may be the cause for commitment to an institution until the disease is no longer communicable. Investigation in cases not under treatment may be made by an officer of the State Board of Health, or, when so directed by the State Board of Health, by any local health officer who is a physician. Sec. 143.07 (2), (4), (5).

Drugs commonly used for treatment of syphilis are furnished by the State Board of Health on request to physicians submitting morbidity reports as required by the U. S. Public Health Service. Physicians having patients unable to pay for treatment for venereal disease may assign such individuals to state clinics for treatment.

When a patient refuses treatment the physician shall notify the State Board of Health, giving particulars, to enable the Board to act, and, if necessary, to have the person committed for treatment. In counties of over 250,000 population, the county board may designate the county institution where such commitments may be made. Such persons may be summoned before any court of record or a warrant may be issued for them. Sec. 143.07(5).

When a physician has reported a case of venereal disease to the State Board of Health, all questions regarding the presence of the disease and the date from which treatment was neglected shall not be regarded as privileged information when the patient or physician is called upon to testify to the facts before any court of record. Sec. 143.07(7).

Physicians shall be furnished free of charge with the results of examinations for the diagnosis of gonorrhea made by any state laboratory, and of examinations of blood or secretions for the diagnosis of syphilis from the Wisconsin Psychiatric Institute. Sec. 143.07 (10).

Any city or county may require that persons convicted of acts involving moral turpitude shall undergo a medical examination for the presence of a venereal disease.

No physician or health officer shall issue a certificate of freedom for any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons, or show, for immoral purposes, venereal disease reports from any laboratory.

All cases of venereal disease shall be regarded as communicable until the following requirements have been met: Until open sores are healed; until satisfactory care and treatment have been given pregnant women with syphilis, females who have given birth to a syphilitic child, syphilitic persons at any stage of the disease who reasonable evidence indicates are promiscuous in sexual relations and are a menace to others, and persons with early syphilis not adequately treated. Trained public health nurses and health officers are available to physicians in the state, from the State Board of Health, for finding and holding cases of venereal disease.

Physician protected from liability.—A physician who reports to the State Board of Health the name of a person afflicted with a venereal disease on account of such person not continuing treatments until the disease is no longer communicable will be protected from liability, if the facts justify his action. 8 Atty. Gen. 561.

Infant blindness.—The attending physician (or midwife) is required to use a 1 per cent silver nitrate solution in the eyes of newborn babies. For the prevention of ophthalmia neonatorum the State Board of Health is required to supply the solution free to every physician (and midwife), put up in proper containers and distributed to health officers for delivery to practitioners.

When ophthalmia neonatorum appears in any newborn babe not attended by a physician or midwife and the case is reported, as required, to the health officer, a competent physician shall be employed by the municipality to examine and treat the infant

as directed in the instructions accompanying the solution. The penalty for violation of any part of this law is a fine up to $100. Sec. 146.01.

Laboratory examination for venereal disease.—The state laboratory of hygiene and branch and cooperative laboratories shall make microscopical examinations for the diagnosis of gonorrhea, and the Psychiatric Institute the necessary examinations of blood or secretions for the diagnosis of syphilis, for any physician in the state, without charge.

The law requires that all laboratories doing tests for syphilis and gonorrhea report their positive tests together with the name of the physician making the test on blanks provided by the State Board of Health.

Venereal disease, indigents.—The county is required to pay for the care and treatment of indigent persons afflicted with a venereal disease. 8 Atty. Gen. 559.

The county is responsible for one-half of the per capita cost for the care and treatment of indigents committed to state institutions for the treatment of venereal disease. Sec. 143.07 (6).

Tuberculosis.—Every physician is required to report within one week cases of tuberculosis in his care or under his observation. The report shall contain the name and address, age and sex of the case. Report blanks will be furnished by the State Board of Health.

Voluntary admission to a tuberculosis sanatorium in Wisconsin can be obtained (Chapter 50) by having the patient or his representative appear before a county judge of the county in which he has legal settlement or in which he is residing. If the patient has a legal residence or has resided in the state for an aggregate of five years or more, he may be admitted without charge. Report of the examining physician and judge's orders are transmitted to the sanatorium where the patient may be admitted by the superintendent when a vacancy occurs.

Cancer

Since 1933, cancer has been reportable by law to the State Board of Health. In August 1946, the Board of Health created a Division of Cancer Control. This division, in cooperation with medical, cancer, and hospital groups, is establishing a statewide cancer registry for the purpose of studying the disease at local and state levels. The division also provides educational materials for the laity, and symposia and diagnostic aids for physicians.

Epilepsy Reportable

The 1947 legislature enacted legislation pertaining to epilepsy as follows:

146.23 Epileptics, duty to report. (1) The state board of health shall by order promulgate a definition of epilepsy which shall govern in carrying out the provisions of this section and sections 140.05 (13) and 141.08.

(2) All physicians shall report immediately to the local health officer in writing, the name, age, and address of every person diagnosed as afflicted with epilepsy or similar disorder characterized by lapses of consciousness.

(3) The local health officer shall report in writing to the state board of health the name, age, and address of every person reported to it as an epileptic.

(4) The state board of health shall report to the motor vehicle department the names, ages, and addresses, of all persons reported to it as epileptics by physicians and local health officers.

(5) Such reports shall be for the information of the motor vehicle department in enforcing the provisions of chapter 85 of the statutes and shall be kept confidential and used solely for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of this state.

In compliance with the provisions of the act, the State Board of Health, on September 5, 1947, promulgated the following definition of epilepsy:

"An affection of the nervous system characterized by attacks of unconsciousness, with or without convulsions, shall be considered as epilepsy in carrying out the provisions of section 146.23, 140.05 (13) and 141.08 of the Wisconsin Statutes."

Maternal and Child Health

Postgraduate Medical Programs.—The work of this bureau is primarily educational, and funds are available to bring obstetricians and pediatricians to Wisconsin to participate in postgraduate medical programs, either as part of a planned program covering several days of intensive work, or as lecturers to state or local medical society meetings or open meetings in connection with the medical schools. Interested medical societies should contact the bureau or the State Medical Society office.

Statistical Analysis.—Help is provided in obtaining statistical information and in analyzing data available from birth, death, and stillbirth certificates for physicians interested in study of local problems in their own communities or in hospitals.

Services to Hospitals.—Advisory and demonstration services or special classes for hospital staffs in obstetric and neonatal nursery technics are provided on request. Special emphasis is placed on care of premature babies. A limited number of grants can be made as stipends for local nurses in charge of obstetric or nursery services, to obtain special training in the care of premature infants. A number of commercial incubators are available for loan to hospitals for demonstration purposes.

Incubators.—Any physician needing an incubator for premature infants born at home, or for transportation or care of infants on release from the hospital should contact the local public health nurse

or district health officer. The public health nurse will be glad to make home visits and assist the family in following the physician's instructions when special care is indicated.

Maternity Classes.—Local programs in parent education are encouraged through advisory and demonstration service. Preparation for parenthood and child care is included. Physicians may refer parents of young children and expectant parents to the local public health nurse for group instruction or individual teaching and demonstration of care in the home.

Prenatal Letter Service.—Special forms are provided physicians for enrolling their obstetric patients for the prenatal letter service. Patients enrolled receive the booklet on prenatal care, wall card —health habits in pregnancy, and monthly letters during pregnancy. Later the booklet on infant care is provided, with diet and development cards for the first two months. At intervals throughout the first year of the infant's life letters and diet and development cards are sent to remind mothers of the need for returning to the physician for health supervision, immunization, and vaccination.

Nutrition.—The staff nutritionists participate in pre-service and in-service training programs to provide nurses, teachers, and other professional workers with basic nutrition information and to keep them informed as to new developments in the field of nutrition. In cooperation with the State Department of Public Instruction technical assistance is provided to local school administrators in the organization and operation of good school lunch programs with special emphasis on the nutritive value of the lunch, educational values, and proper sanitation. Dietary consultation service also is available to child-caring institutions, children's camps, and small hospitals. Physicians interested in consultation service or educational material for individuals or hospitals they serve can obtain such service directly or through the district health office.

School Health.—Physicians will be interested in the type of guidance card now in use in many schools throughout Wisconsin, especially if they are participating in a local school health program. The bureau is providing special training programs for teachers, advisory service, and educational materials for use in improving the health of school children.

Literature.—Physicians may obtain supplies of any of the literature available through the bureau for their own office use. They are, however, urged to avoid duplication of distribution in as far as possible. Similar literature is sometimes distributed by the county nurse, and much of the material goes to any woman enrolled for the prenatal letter service.

Emergency Maternity and Infant Care.—The war program is in the process of liquidation. However, individuals eligible prior to July 1, 1947 remain eligible. Although there will be but a short period during which obstetric applications can be cleared, infants born under the EMIC plan remain eligible for periods of illness during the first year of life. Refer to *The Wisconsin Medical Journal*, June 1946 issue, page 630, for details of eligibility.

Mental Health

Attention is called to the expansion of this program made possible through the extension of the U. S. Public Health Service activities into the area of mental health. Monies allocated to the State Department of Health are being used to make available to the physicians of Wisconsin more consultation and referral services, by the promotion of local mental health centers. These centers are under the direction of psychiatrists. Diagnosis, plan for management, and treatment, whether environmental or individual, are offered.

A fund has been set aside to carry on an educational program for lay and professional people. Medical societies can receive financial assistance in bringing to their meetings speakers on psychiatry, psychosomatic medicine, behavior disorders, and children's problems. Bulletins, films, radio transcriptions, and leaflets for educational purposes are supplied on request.

State Laboratory of Hygiene

Physicians shall be furnished free of charge with results of laboratory analyses of specimens sent for determining diagnosis of disease. Laboratories are located at Madison, Rhinelander, Oshkosh, Green Bay, Superior, Beloit, Kenosha, Wausau, Sheboygan and La Crosse.

The materials which are examined in these laboratories are sputum for tubercle bacilli; swabs for diphtheria bacilli and other organisms; pus for gonococci and other organisms; central nervous systems of dogs and other animals for Negri bodies diagnostic of rabies; spinal fluid for meningococci and other organisms; materials in suspected cases of anthrax, glanders and actinomycosis; blood, feces and urine for the diagnosis of typhoid and paratyphoid fever (blood only for tularemia and undulant fever) or to detect carriers of these germs; and chemical and bacteriologic examination of water to detect its fitness for drinking purposes. The examination of tissue in suspected cases of malignancy is done only in the laboratory in Madison, and only in those cases wherein the patients are unable to pay a special fee. Such tests are made free for physicians, and the facilities of the laboratories are urged upon the physicians of Wisconsin in the effort to detect and combat communicable disease. Pneumonia typing is now a valuable service offered by the laboratories.

State biologic products.—Under the law, local boards of health are required, under the direction of the State Board of Health, to furnish antitoxin

to indigents suffering from communicable diseases. The State Laboratory of Hygiene at Madison has available for distribution free of charge to physicians in the state typhoid-paratyphoid vaccine and whooping cough vaccine. Tuberculin diluted 1 to 1,000 is available for group testing by the Mantoux test.

Vital Statistics

There have been no changes in the procedure required for filing births, stillbirths, and death records as they affect medical practitioners in Wisconsin.

The 1947 legislature enacted the following new law (Chapter 269), directly affecting physicians:

"**366.20 Reporting Deaths Required; Penalty.**

(1) All physicians, authorities of hospitals, sanitariums, institutions (public and private), convalescent homes, authorities of any institution of a like nature, and other persons having knowledge of the death of any person who shall have died under any of the following circumstances listed below, shall immediately report such death to the sheriff, police chief, or coroner of the county wherein such death took place:

(a) All deaths in which there are unexplained, unusual or suspicious circumstances.

(b) All homicides.

(c) All suicides.

(d) All deaths following an abortion.

(e) All deaths due to poisoning, whether homicidal, suicidal or accidental.

(f) All deaths following accidents, whether the injury is or is not the primary cause of death.

(g) When there is no physician in attendance.

(h) When a physician refuses to sign the death certificate.

(2) Any person who shall violate this section shall be punished by a fine of not less than $5, nor more than $200, or by imprisonment not less than 30 days nor more than 3 months."

Pertinent sections of Chapter 69 Wisconsin Statutes providing for certain duties of reporting births, stillbirths, and deaths attended by physicians are reprinted herewith:

"**69.30 Birth certificates by physicians, midwives and others; Milwaukee county.** (1) The physician or midwife in attendance upon any birth shall file a certificate of birth, properly and completely filled out, giving all the particulars required by this chapter, with the register of deeds of the county in which the birth occurred within 5 days after birth, except that in cities such certificate shall be filed with the health officer. In counties having a population of 500,000 or more, the register of deeds and the city health officer shall, within 10 days after the filing of an original birth certificate, make an exact copy of such birth record whenever the parents of the child born were residents of any town or village in such county, and shall transmit such copies to the town or village clerk without fee or charge therefor. All certificates for illegitimate births subsequent to October 1, 1907 shall be kept in a separate file and shall be subject to public inspection only upon court order, except for obtaining proof of heirship. A copy of an illegitimate birth record shall be furnished only upon the order of any county judge or judge of the juvenile court. All charges for professional services rendered by the physician or midwife in attendance upon a birth shall be unlawful if the birth certificate, properly filled out, is not reported as herein provided.

(2) If there be no attending physician or midwife, then the father of the child, householder or owner of the premises, manager or superintendent of a public or private institution in which the birth occurred shall file a satisfactory certificate of birth with the register of deeds, or city health officer, within 5 days as provided in section 69.09."

"**69.34 Stillbirths.** The certificate of stillbirth shall contain such items as the state board of health determines are necessary. The funeral director or person acting as such shall be responsible for filing the certificate before obtaining a burial permit, and shall have the items pertaining to the cause and conditions of the stillbirth filled in and signed by the physician or other person attending the birth. In case the birth was unattended, the local registrar or the coroner shall state over his signature such facts as can be ascertained about the birth in the space so provided."

"**69.38 Physician's certificate, causes of death.**

(1) The certificate of death shall be made and signed by the physician last in attendance on the deceased and shall specify the time in attendance, the time he last saw the deceased alive, and the hour and the day at which death occurred.

(2) He shall state the causes of death so as to show the course of disease or sequence of causes resulting in death, and the duration of each.

(3) Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from diseases are not sufficient for issuing a burial or removal permit and any certificate containing only such terms shall be returned to the physician for correction and definition.

(4) Causes of death which may be the result of either disease or violence shall be carefully defined, and, if from violence, its nature shall be stated, and whether accidental, suicidal or homicidal.

(5) In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required under this head and shall state where, in his opinion, the disease was contracted.

(6) And the cause of death and all other facts required shall in all cases be stated in accordance with the rules and regulations of the state registrar."

"**69.45 Funeral director's duties as to certificate and permit.** (1) The funeral director, or person acting as funeral director, shall be responsible for obtaining and filing the certificate of death with the registrar and securing from him a burial or removal permit prior to any disposition of the body.

(2) He shall obtain the personal and statistical particulars required from the person best qualified to supply them over the signature and address of his informant. He shall then present the certificate to the attending physician or other person authorized by law to fill out the medical certificate of the cause of death and other particulars necessary to complete the record, as specified in sections 69.35 to 69.41. He shall then state the facts required relative to the date and place of burial over his signature and his address, and present the completed certificate to the registrar who shall then issue a burial or removal permit.

(3) The undertaker shall deliver the burial permit to the sexton or person in charge of the place of burial before interring the body, or attach the removal permit to the box containing the corpse, when shipped by any transportation company, to accompany the same to destination."

"**69.26 Fees of informants, counties to pay.** (1) Each physician, midwife, minister or priest, court commissioner, judge of a court of record, justice of the peace or other persons acting as informant and filing with the local registrar or the register of deeds, as the case requires, certificates of births, stillbirths, deaths and marriages completely and legibly made out in ink, shall be entitled to 25 cents for each birth, stillbirth, death and marriage so filed, to be paid by the treasurer of the county upon certification by the state registrar.

(2) Only one certificate shall be filed for each birth, stillbirth, death and marriage and the order of right to file the certificate shall be the same as the order of responsibility for filing as herein given.

(3) Informants transmitting defective certificates shall not be entitled to payment until the missing information, when possible to obtain, is supplied.

(4) The state registrar shall annually certify to the county clerks of the several counties, the number of births, stillbirths, deaths and marriages registered with the names of the person reporting and the amounts due each at the rate fixed herein, whereupon the county clerks shall certify such amounts to the county treasurer for payment to the persons entitled thereto.

(5) Any person entitled to such fee shall claim and demand the same within 3 years after receipt by the county treasurer of the warrant or certificate from the state registrar authorizing such payment, and no right to such fee shall exist after the expiration of such time."

"**69.55 Penalties for violating this chapter.** Any person who shall wilfully violate any of the provisions of chapter 69, or who shall neglect or refuse to perform any duty or do any act imposed upon him as required by said chapter, or who shall neglect or refuse to make any certificate required by said sections to be made, or falsely make any such certificate, or knowingly make any false statement in any such certificate, or shall alter any certificate or report provided for as required by said chapter shall be punished by a fine of not less than $20 or more than $200 for each offense, or by imprisonment in the county jail for a period of not less than 30 days or more than 60 days, or by both such fine and imprisonment."

County, City-County and Multiple County Health Departments

Legislation covering this type of health department development appears in Chapter 511 of the Laws of 1947. Each single county health department is to be managed by a board of health of five to seven members. Two of the members must be physicians practicing in the county; one member must be a dentist. In the case of city–county health departments, the board of health will consist of seven members, two members of which are to be physicians. In the case of multiple county health departments, three members are appointed from each county and one of the three members will be a physician.

The county health officer must be a licensed physician especially trained in public health and will be appointed by the local board of health from an eligible list submitted by the State Board of Health.

Such a board of health when established in any county shall have all the powers and authority now vested in local boards of health. It may adopt rules for its own guidance and for the government of the health department as may be deemed necessary to protect and improve the public health of that area.

The health department will be financed by each participating county and city, the cost being divided proportionately on the basis of equalized valuation. In the case of a multiple county health department the funds shall be deposited in the treasurer's office of the county wherein is located the principal office of the department. In the case of a city–county health department the funds may be deposited either in the treasurer's office of the county or in the city treasurer's office.

Any county board may organize a single county department of health by resolution or several counties may pass a resolution joining up with adjacent counties. In the case of a city–county department of health, it is necessary for both the city and the county to pass resolutions, or the city may decide to join with the county by passage of an ordinance. If more than three counties desire to form a multiple county health department, prior approval from the State Board of Health is needed.

Community Diagnostic Services

THERE are now 15 community psychiatric services to which physicians may refer emotionally disturbed persons when special help is necessary. In several places psychologists and social workers cooperate to form a complete mental hygiene clinic. Diagnostic, treatment, and consultation services are located in the following areas:

BROWN COUNTY: 523 Howe Street, Green Bay
- Established 1942 as demonstration by State Department of Health
- Full-time psychiatric services; financed by County

COLUMBIA COUNTY: Court House, Portage
- Part-time psychiatric services supported by County
- Part-time clinical psychologic service being demonstrated by State Department of Health

DANE COUNTY: 22 No. Hancock Street, Madison
- Established 1944 as demonstration by State Department of Health
- Full-time psychiatric social worker now financed by Community Chest
- Part-time psychiatric and full-time clinical psychologic service now being demonstrated by State Department of Health. Used as training center

DODGE COUNTY: Court House, Juneau
- Established 1944 as demonstration by State Department of Health
- Part-time psychiatric service now supported by County
- Part-time clinical psychologist being demonstrated by State Department of Health

FOND DU LAC COUNTY: Court House, Fond du Lac
- Demonstration 1943 to 1945 by State Department of Health
- Part-time psychiatric service now supported by County

JEFFERSON COUNTY: Court House, Jefferson
- Part-time psychiatric service established and financed by County
- Part-time clinical psychologic service being demonstrated by State Department of Health

KENOSHA COUNTY: Vocational School, Kenosha
- Part-time psychiatric service supported by Kenosha Mental Hygiene Society

LA CROSSE COUNTY: La Crosse
- Part-time psychiatric service demonstrated by State Department of Health

MILWAUKEE COUNTY: Public Safety Building, Milwaukee
- Established in 1928; two full-time psychiatrists, three full-time clinical psychologists, four full-time psychiatric social workers financed by county

RACINE COUNTY: City Hall, Racine
- Established 1942 as demonstration by State Department of Health. Now part-time psychiatrist and full-time social worker supported by Community Chest

ROCK COUNTY: Court House, Janesville
- Established 1943 as demonstration by State Department of Health
- Part-time psychiatric services now financed by County. Part-time clinical psychologic services being demonstrated by State Department of Health

SHEBOYGAN COUNTY: Sheboygan
- Established 1944 as demonstration by State Department of Health. Now part-time psychiatric service financed by Service League

WAUKESHA COUNTY: Waukesha
- Established and supported by Waukesha County Council for Child Welfare
- Part-time psychiatric service

WINNEBAGO COUNTY: Oshkosh
- Established 1942 as demonstration by State Department of Health
- Part-time psychiatric service now supported by County

WISCONSIN GENERAL HOSPITAL, PSYCHIATRIC DIVISION: 1300 University Avenue, Madison

Laws and Rules For the Tuberculous

PHYSICIANS are interested in laws affecting the care of their tuberculous patients. A law providing for the free care of the tuberculous became effective May 5, 1945. Under its provisions, any legal resident of a municipality of the State of Wisconsin is entitled to free care when he enters a tuberculosis sanatorium, provided that he does not wish to pay for part or all of his care, and provided that he has no hospital insurance which covers his care. Should he have hospital insurance, it will apply on his care for the period of time specified in the policy and any difference between the amount which the policy pays and the amount necessary for his complete maintenance is to be at public expense. At the expiration of his policy he becomes a full public charge.

A state-at-large case must have resided in this state for a total of five years sometime prior to admission to the sanatorium, and if he be a minor, the resident requirement applies to his parent or guardian. If he has not resided in the state 5 years, then it still remains up to the county judge to determine whether or not such a state-at-large case has the ability to pay for his care.

The other change refers to the commitment law which was strengthened. Formerly it was necessary to have the diagnosis of tuberculosis confirmed by a positive sputum in a state laboratory or a municipal laboratory approved by the State Board of Health before the patient could be committed to a sanatorium. Under the amended provisions effective June 7, 1945, a person may be committed if his diagnosis has been made by a medical examination, a laboratory, or an x-ray examination if he fails to comply with the State Board of Health rules and regulations relating to the disease.

Statute

Extracts from Section 143.06 of the Wisconsin Statutes follow:

"(2) Every person sick with tuberculosis, or in attendance, and the authorities of such places, shall observe and enforce the rules and regulations of the health board for preventing spread.

"(4) If any person afflicted with tuberculosis, diagnosis of which is made by a medical examination, laboratory or X-ray examination or as shown by the examinations made in the state laboratory of hygiene, in any branch and co-operative laboratory or in any municipal laboratory accredited by the state board of health or in any federal governmental laboratory, fails to comply with this section, or the tuberculosis rules of the state board of health, he may be committed to a county tuberculosis hospital or other place or institution where proper care will be provided and where the necessary precautions will be taken, by any judge of a court of record upon proof that such person has so offended. Such person shall, upon verified petition setting forth the facts by any health officer or any resident of the municipality where the alleged offense was committed, be summoned by such judge to appear at the time and place stated in the summons, which time shall not be less than 48 hours after service. The court may make such order for payment for care and treatment as may be authorized by law. Such person may be discharged when the court thinks proper. If the superintendent has good cause to believe that any person so committed may leave the institution he may restrain him from leaving. Whenever the superintendent deems it necessary he may segregate any person so committed. If any person so committed shall escape, the superintendent may take such lawful steps as he may deem necessary to secure his return. * * *"

Rules For the Tuberculous

The rules and regulations which the infected individual must comply with are quoted in part as follows:

"All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:

1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
3. Using individual eating utensils sterilized by boiling after each use.
4. Using separate towels.
5. Sleeping alone.
6. Avoiding coming in contact with other persons on all possible occasions.
7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.

"Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by X-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be quarantined on his premises by the local board of health or the health officer on the direction of the State Board of Health or State Health Officer, or by

the full-time Medical Health Officer of any city or county with a population of 250,000 or more within his jurisdiction.

* * *

"No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

* * *

"If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be quarantined upon his premises as provided in Section B if in the opinion of the State Board of Health or the State Health Officer or of the full-time Medical Health Officer of cities or counties with a population of 250,000 or more, agree that quarantine is necessary in order to protect others from becoming infected."

1948 MIDWEST RADIOLOGIC CONFERENCE

The Eighth Annual Midwest Radiologic Conference will be held at Hotel Schroeder in Milwaukee on February 6 and 7, and will be followed by the annual conference of teachers of radiology in Chicago on February 8. The Radiologic Conference is sponsored by the Milwaukee Roentgen Ray Society, and inquiries concerning details of the meeting may be addressed to Dr. A. Melamed, Secretary, Milwaukee Roentgen Ray Society, 425 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

The program is as follows:

FRIDAY MORNING

8:30–9:30 Registration

Irving I. Cowan, M. D., Chairman

9:30 Address of Welcome
J. C. Griffith, M. D., President, Medical Society of Milwaukee County

9:45 The Collapse Therapy of Pulmonary Tuberculosis from a Roentgenological Standpoint
John D. Steele, M. D., Assistant Clinical Professor of Surgery, Marquette University

10:05 Diagnostic and Therapeutic Aspect of Tumors of the Hypophyseal Region
Joseph Mufson, M. D., Department of Neurosurgery, Milwaukee County Hospital

10:25 The Effect of Splenic Irradiation on the Vascular Lesions in Purpura
Frederick W. Madison, M. D., Associate Clinical Professor of Medicine, Marquette University

10:45 The Treatment of Leukemia and Other Blood Disorders with Urethane
John S. Hirschboeck, M. D., Dean, Marquette University, School of Medicine

11:05 Congenital Cardiac Lesions Simulating Tetraology of Fallot
Francis F. Rosenbaum, M. D., Assistant Clinical Professor of Medicine, Marquette University

11:25 The Importance of Cholangiograms in Common Duct Surgery
Carl W. Eberbach, M. D., Associate Clinical Professor of Surgery, Marquette University

11:45 Cardiac Roentgenology in Patients over Forty
J. Edwin Habbe, M. D., Associate Clinical Professor of Radiology, Marquette University

12:00–1:30 Intermission

FRIDAY AFTERNOON

J. Edwin Habbe, M. D., Chairman

1:30 Etology and Pathogenesis of Prolapsed Gastric Mucosa into the Duodenum
A. Melamed, M. D., Radiologist Deaconess Hospital, Milwaukee

1:50 Intussusception in Children
Arthur Schaefer, M. D., Associate Clinical Professor of Surgery, Marquette University and John L. Armbruster, M. D., Clinical Instructor of Radiology, Marquette University

2:10 The Diagnosis of Malignancies by Smear Technique
Leander J. Van Hecke, M. D., Assistant Professor of Pathology and Bacteriology, Marquette University

2:30 The Excretory Urogram as a Test of Renal Function
James C. Sargent, M. D., Clinical Professor and Director of the Division of Urology, Marquette University

2:50 Diagnosis of Small Esophageal Hiatus Hernias
S. Archibald Morton, M. D., Clinical Processor and Director of the Division of Radiology, Marquette University

3:10 The Production of High Energy Electron Beams and Their Possible Use in Medical Therapy
Jack T. Wilson, Ph.D., Physicist, Allis-Chalmers Manufacturing Company, Milwaukee

3:30 Diagnostic and Therapeutic Aspects of Tumors of the Testicle
S. B. Pessin, M. D., Associate Professor of Pathology and Bacteriology, Marquette University, and Irving I. Cowan, M. D., Clinical Instructor in Radiology, Marquette University

3:50 Diagnostic Problems of the Esophagus
Gerhard D. Straus, M. D., Clinical Instructor in Otolaryngology, Marquette University

4:10 Radiation Therapy Problem Clinic
Irving I. Cowan, M. D., Moderator
R. R. Newell, M. D., Professor of Radiology, Stanford University, San Francisco, California
Ernst A. Pohle, M. D., Professor of Radiology, University of Wisconsin

FRIDAY EVENING

6:00 Fellowship Hour
Sponsored by the Film and Equipment Manufacturers

7:00 Informal Banquet
Guest Speaker: R. R. Newell, M. D., Professor of Radiology, Stanford University, School of Medicine, San Francisco, California
"Doctors Duties and Opportunitics in the New Age of Atomic Energy"

SATURDAY MORNING

Hans Hefke, M. D., Chairman

9:30 Symposium and Round Table Discussion of "Fractures in Children"
Fractures of the Lower Extremity in Children
Walter P. Blount, M. D., Attending Staff Columbia Hospital, Children's Hospital, and Consulting Staff, County Hospital
Fractures of the Humerus and Forearm in Children
Albert C. Schmidt, M. D., Assistant Clinical Professor of Orthopedic Surgery, Marquette University
Fractures of the Elbow in Children
Irwin Schulz, M. D.

10:30 Film Study Session
S. A. Morton, M. D., Moderator
Hans Hefke, M. D., Clinical Professor of Radiology, Marquette University
Theodore Pfeffer, M. D., Clinical Instructor in Radiology, Marquette University
L. W. Paul, M. D., Associate Professor of Radiology, University of Wisconsin

Officers of State Boards and Commissions

Basic Science Examiners

Prof. Michael F. Guyer, President, Zoology Department, University of Wisconsin, Madison, 1949

Prof. William H. Barber, Secretary, Watson and Scott Streets, Ripon, 1951

Mr. Milton H. Weeks, Superior

State Board of Medical Examiners

H. H. Christofferson, M. D., President, Colby, 1949

C. A. Dawson, M. D., Secretary, River Falls, 1951

Alvin G. Koehler, Oshkosh, 1951

A. F. Rufflo, M. D., Kenosha, 1949

E. W. Miller, M. D., Milwaukee, 1949

J. W. Smith, M. D., 324 East Wisconsin Avenue, Milwaukee, 1951

J. W. Prentice, Ashland, 1951

State Board of Health

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Gunnar Gundersen, M. D., President, La Crosse, 1951

I. F. Thompson, M. D., Vice-President, Route 4, Box 8C, Beloit, 1952

S. E. Gavin, M. D., Fond du Lac, 1950

Stephen Cahana, M. D., Milwaukee, 1948

W. T. Clark, M. D., Janesville, 1949

S. L. Henke, M. D., Eau Claire, 1953

Forrester Raine, M. D., Milwaukee, 1954

C. N. Neupert, M. D., State Health Officer, Secretary, Madison

Committee on Nursing Education

M. H. Steen, M. D., State Medical Society, Oshkosh, 1949

Rev. William G. Sodt, Milwaukee Hospital

Rev. Edmund J. Goebel, Superintendent Catholic Schools, Archdiocese of Milwaukee, Milwaukee, 1947

Sister M. Augusta, Marquette College of Nursing, Milwaukee, 1949

Miss Clara Bumiller, Wisconsin State Nurses' Association, Milwaukee, 1949

Miss Evelyn Mercer, Milwaukee County Hospital School of Nursing, 1949

Miss Ruth Coe, Madison Vocational School, 1949

C. N. Neupert, M. D., State Health Officer, Madison

Miss Adele G. Stahl, Director, State Bureau of Nursing Education, Madison

Miss Janet Jennings, R. N., Supervisor, Bureau of Public Health Nursing, State Board of Health, Madison

Bureaus and Divisions of State Board of Health

General Administration

C. N. Neupert, M. D., State Health Officer

E. H. Jorris, M. D., Assistant State Health Officer

C. A. Harper, M. D., Medical Specialist in Public Health

Communicable Diseases and Social Hygiene
Arthur R. Zintek, M. D.

Industrial Hygiene
Paul A. Brehm, M. D., Director

Tuberculosis Control
Allan Filek, M. D., Acting Director

Maternal and Child Health
Amy Louise Hunter, M. D., Chief

Mental Health
Eugenia Cameron, M. D., Director

Health Education
Mrs. Catherine K. Campbell

Nutrition
Miss Lucille Billington, Director

Laboratories
W. D. Stovall, M. D., Director

Local Health Services
Allan Filek, M. D., Director

Venereal Diseases
(Vacancy)

Vital Statistics
Mr. Paul Weis, Assistant Registrar

Nursing Education
Miss Adele G. Stahl, R. N., Director

Public Health Nursing
Miss Janet Jennings, R. N.

Barber Shops
Mr. Charles Mullen, Supervisor

Cosmetology
Mrs. Marion Groth, Supervisor

Funeral Directors and Embalmers
(Vacancy)

Hotels and Restaurants
Mr. Harold F. Olsen, Supervisor

Plumbing and Domestic Sanitary Engineering
Mr. Walter Spencer, Supervisor

Sanitary Engineering
Mr. L. F. Warrick, State Sanitary Engineer

Well Drilling
Mr. Louis Watry, Supervisor

Editor
John Culnan

Hospital Survey and Construction
Vincent F. Otis, Director

District Health Officers

1. Madison—A. V. de Veneu, M. D., Wyocena
2. Elkhorn—E. E. Bertolaet, M. D., Elkhorn
3. Fond du Lac—(Vacancy)
4. Sparta—(Vacancy)
5. Wisconsin Rapids—(Vacancy)
6. Green Bay—(Vacancy)
7. Chippewa Falls—C. C. Burski, M. D.
8. Rhinelander—Frances A. Cline, M .D.
9. Ashland—Margaret Hatfield, M. D.

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control, and combining certain other agencies.)

Members of the Board

Mr. Herman A. Kloppmann, Chairman, Crivitz, 1951
Mr. John M. McHale, Vice-chairman, Green Bay, 1951
W. D. Stovall, M. D., Secretary, Madison, 1949
Mr. Charles H. Liehe, Chippewa Falls, 1953
Mrs. H. L. Garner, Madison, 1953
George R. Baker, M. D., Tomahawk, 1949
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Executive Staff

Mr. A. W. Bayley, Madison, Director
Division of Corrections:
Mr. Paul D. Yount, Director
Division of Mental Hygiene:
W. J. Urben, M. D., Madison, Director
Division of Public Assistance:
Mr. George M. Keith, Madison, Director
Division of Administration and Research:
Mr. H. B. Evans, Madison, Director
Division of Child Welfare:
Miss Elizabeth Yerxa, Madison, Director
Division of Adult Blind Services:
Mr. E. F. Costigan, Milwaukee, Director

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1949
Mr. Harry J. Burczyk, 1953
Mr. C. L. Miler, 1951
Miss Helen Gill, Secretary

Workmen's Compensation Department

Mr. Harry A. Nelson, Director

Unemployment Compensation Department

Mr. Paul Raushenbush, Director

Safety and Sanitation Department

Mr. Robert McA. Keown, Director

State Board of Vocational and Adult Education

Employee Members

E. J. Fransway—Wauwatosa
Emil Waldow—Green Bay
Frank C. Horyza—Superior

Employer Members

Jessel S. Whyte—Kenosha
Alfred A. Laun—Kiel
Fred Vogt—Milwaukee

Farmer Members

John Last—Lake Mills
John Wiechers—Racine
Robert L. Pierce—Menomonie

Ex-Officio Members

John Callahan—Madison
Voyta Wrabetz—Madison
C. L. Greiber—Madison
State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Office

Room 320, State Office Building, Madison, Wisconsin

W. F. Faulkes—Chief
J. H. Brown—Assistant Chief

State Supervisory Staff

O. H. Johnson—Research and Promotion
Chas. Beardsley—Case Service
Irene M. Dunn—Records
A. E. Towne—Physical Restoration Service
Mary F. Beyer—Homecraft

District Offices

Madison—114 North Carroll Street
C. D. Rejahl, District Supervisor
Milwaukee Vocational School Bldg.
—1015 N. 6th Street
L. A. Rumsey, District Supervisor
Green Bay Vocational School Bldg.
—200 S. Broadway
A. W. Bouffard, District Supervisor
Eau Claire Vocational School Bldg.
—1300 First Avenue
F. A. Campbell, District Supervisor

Local Offices

Carl Haase—Case Supervisor
La Crosse Vocational School Building
V. C. Bryan—Case Supervisor
Racine Vocational School Building
L. H. Heise—Case Supervisor
Wausau Vocational School Building
H. C. Ritzman—Case Supervisor
Superior Vocational School Building

STATE MEDICAL ADVISORY COMMITTEE

T. J. Howard, M. D.—Milwaukee
G. F. Wakefield, M. D.—West Salem
J. K. Trumbo, M. D.—Wausau
J. S. Supernaw, M. D.—Madison
R. M. Kurten, M. D.—Racine
H. L. Greene, M. D.—Madison
H. M. Coon, M. D.—Madison
C. N. Neupert, M. D.—Madison
Charles Fidler, M. D.—Milwaukee
H. H. Reese, M. D.—Madison
H. J. Heeb, M. D.—Milwaukee
Miss Marjorie Taylor—Milwaukee
Miss Janet Jennings—Madison

The State Medical Society of Wisconsin

1949 Officers and Committees

President

Dr. W. D. Stovall
Service Memorial Institute
Madison

President-Elect

Dr. K. H. Doege
Marshfield

Secretary

Mr. C. H. Crownhart
917 Tenney Building
Madison 3

Assistant Secretary

Mr. Roy T. Ragatz
917 Tenney Building
Madison 3

Treasurer

Dr. I. R. Sisk
1 South Pinckney Street
Madison 3

Speaker, House of Delegates

Dr. Gunnar Gundersen
La Crosse

Vice-Speaker

Dr. A. A. Cantwell
Shawano

Councilors*

(Dr. S. E. Gavin, Fond du Lac, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. J. F. Wilkinson, Oconomowoc, 1948.

Second: Kenosha, Racine and Walworth County Societies. Dr. T. C. Hemmingsen, 1332 State Street, Racine, 1948.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies, Dr. C. O. Vingom, 122 West Washington Avenue, Madison 3, 1949.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1949.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1949.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. S. E. Gavin (chairman), 104 South Main Street, Fond du Lac, 1949.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavian Bank Building, La Crosse, 1950.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Peshtigo, 1950.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. H. H. Christofferson, Colby, 1950.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson, Frederic, 1950.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1948.

Twelfth: The Medical Society of Milwaukee County. Dr. J. W. Truitt, 161 West Wisconsin Avenue, Milwaukee, 1949; Dr. R. E. Fitzgerald, 2218 North Third Street, Milwaukee, 1948; Dr. D. H. Witte, 3405 West Lisbon Avenue, Milwaukee, 1948.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. D. Leahy, Park Falls, 1950.

Dr. C. A. Dawson (Past-President) Tremont Building, River Falls, 1948.

Delegates to American Medical Association

Dr. S. E. Gavin (1948)
104 South Main Street
Fond du Lac

Dr. J. C. Sargent (1948)
324 East Wisconsin Avenue
Milwaukee 2

Dr. W. D. Stovall (1949)
Service Memorial Institute
Madison 6

Alternates

Dr. L. O. Simenstad (1948)
Osceola

Dr. D. H. Witte (1948)
3405 West Lisbon Avenue
Milwaukee

Dr. D. J. Twohig (1949)
Fond du Lac

* Map indicating location of councilor districts, page 128.

Standing Committees

The Committee on Cancer

Dr. W. S. Bump, 1950, chairman, Rhinelander
Dr. J. W. McGill, 1948, 1225 Tower Avenue, Superior
Dr. C. J. Weber, 1948, Sheboygan
Dr. J. D. Wilkinson, 1948, Oconomowoc
Dr. D. J. Twohig, 1948, 11 North Main Street, Fond du Lac
Dr. A. R. Curreri, 1949, 1300 University Avenue, Madison 6
Dr. L. W. Peterson, 1949, Shawano
Dr. R. S. Baldwin, 1949, Marshfield
Dr. L. J. Van Hecke, 1950, 231 West Wisconsin Avenue, Milwaukee 3
Dr. T. J. Kroyer, 1950, Walworth
Dr. H. W. Carey, 1950, Lancaster
Dr. D. C. Beebe, 1950, Sparta
Dr. S. L. Henke, 1950, 314 East Grand Avenue, Eau Claire

The Advisory Committee on Care of Crippled Children

Dr. H. A. Sincock, 1948, chairman, 1507 Tower Avenue, Superior
Dr. C. M. Kurtz, 1948, 1300 University Avenue, Madison 6
Dr. W. P. Blount, 1949, 324 East Wisconsin Avenue, Milwaukee 2
Dr. C. M. Ihle, 1949, 405 Culver Building, Eau Claire
Dr. M. H. Steen, 1950, 19 Jefferson Avenue, Oshkosh
Dr. A. B. Schwartz, 1950, 2018 East North Avenue, Milwaukee

The Committee on Coordination of Medical Services

Dr. S. B. Harper, 1950, chairman, 1 South Pinckney Street, Madison
Dr. S. E. Gavin, 1948, 104 South Main Street, Fond du Lac
Dr. E. F. Tierney, 1949, Portage
President, ex officio
Secretary, ex officio

The Committee on Goiter

Dr. Arnold S. Jackson, 1949, chairman, 16 South Henry Street, Madison 3
Dr. E. W. Schacht, 1949, 423 Main Street, Racine
Dr. R. E. McDonald, 1950, 425 East Wisconsin Avenue, Milwaukee 2
Dr. C. N. Neupert, ex officio, State Office Building, Madison 2
Dr. E. S. Gordon, ex officio, 1300 University Avenue, Madison 6

The Committee on Grievances

Dr. J. W. Prentice, 1949, chairman, 522 West Second Street, Ashland
Dr. A. G. Sullivan, 1948, 16 North Carroll Street, Madison 3
Dr. E. W. Mason, 1950, 324 East Wisconsin Avenue, Milwaukee 2

The Committee on Health and Public Instruction

Dr. Norbert Enzer, 1949, chairman, 425 East Wisconsin Avenue, Milwaukee 2
Dr. L. R. Cole, 1948, 1300 University Avenue, Madison 6
Dr. E. R. Krumbiegel, 1950, 608 City Hall, Milwaukee

The Committee on Hearing Defects

Dr. W. E. Grove, 1949, chairman, 324 East Wisconsin Avenue, Milwaukee 2
Dr. T. L. Tolan, 1948, 324 East Wisconsin Avenue, Milwaukee 2
Dr. W. B. Dimond, 1950, 16 North Carroll Street, Madison

The Committee on Hospital Relations

Dr. J. E. Habbe, 1948, chairman, 231 West Wisconsin Avenue, Milwaukee 3
Dr. A. J. McCarey, 1948, 305 East Walnut Street, Green Bay
Dr. M. L. Jones, 1949, 510½ Third Street, Wausau
Dr. J. W. Smith, 1949, 1803 North Fifty-Seventh Street, Milwaukee
Dr. R. M. Waters, 1950, 1300 University Avenue, Madison 6
Dr. Gorton Ritchie, 1950, 3321 North Maryland Avenue, Milwaukee

The Committee on Industrial Health

Dr. D. E. Dorchester, 1948, chairman, Sturgeon Bay
Dr. E. W. Miller, 1949, 231 West Michigan Street, Milwaukee
Dr. M. L. Jones, 1950, 510 Third Street, Wausau
Dr. L. W. Hipke, ex officio, 425 East Wisconsin Avenue, Milwaukee 2

The Committee on Maternal and Child Welfare

Dr. W. C. Stewart, 1949, chairman, 5825 Sixth Avenue, Kenosha
Dr. L. M. Simonson, 1948, Sheboygan
Dr. J. W. Harris, 1948, 1300 University Avenue, Madison 6
Dr. E. C. Cary, 1949, Reedsville
Dr. Robert F. Purtell, 1950, 758 North Twenty-seventh Street, Milwaukee
Dr. Amy Louise Hunter, 1950, State Office Building, Madison 2

The Committee on Medical Economics and Voluntary Sickness Insurance

Dr. Robert Krohn, 1949, chairman, Black River Falls
Dr. H. B. Norviel, 1948, Phillips
Dr. L. J. Bayer, 1948, Merrill
Dr. H. J. Lee, 1949, 425 East Wisconsin Avenue, Milwaukee 2
Dr. T. A. Leonard, 1950, 110 East Main Street, Madison 3
Dr. L. A. Copps, 1950, Marshfield

The Committee on Medical Education and Hospitals

Dr. F. D. Murphy, 1948, chairman, 536 West Wisconsin Avenue, Milwaukee 3
Dr. P. A. Midelfart, 1950, 314 East Grand Avenue, Eau Claire
Dr. F. J. Pohle, 1949, 1300 University Avenue, Madison 6 (deceased)

Council on Medical Service and Public Relations

Dr. R. G. Arveson, 1951, chairman, Frederic
Dr. C. R. Marquardt, 1948, 324 East Wisconsin Avenue, Milwaukee
Dr. P. M. Currer, 1949, 3122 West North Avenue, Milwaukee
Dr. J. S. Supernaw, 1950, 110 East Main Street, Madison
Dr. J. W. McGill, 1952, 1225 Tower Avenue, Superior
President, ex officio
Past-president, ex officio
Chairman of the Council, ex officio
Speaker of the House of Delegates, ex officio

The Committee on Mental Hygiene and Institutional Care

Dr. H. H. Christofferson, 1950, chairman, Colby
Dr. B. J. Hughes, 1948, Winnebago
Dr. O. H. Epley, 1949, New Richmond

The Committee on Public Policy

Dr. S. E. Gavin, 1947, chairman, 104 South Main Street, Fond du Lac
Dr. C. A. Dawson, 1948, River Falls
Dr. Hart Stang, 1949, 122 South Barstow, Eau Claire
President, ex officio
President-elect, ex officio
Secretary, ex officio

The Committee on Rural Health and Accident Prevention

Dr. R. L. MacCornack, 1949, chairman, Whitehall
Dr. A. A. Filek, 1950, State Office Building, Madison 2
Dr. J. J. Minahan, 1948, Chilton

The Council on Scientific Work (Five-Year Memberships)

Dr. C. F. Midelfort, 1948, chairman, 1836 South Avenue, La Crosse
Dr. E. R. Schmidt, 1949, 1300 University Avenue, Madison 6
Dr. J. M. Freeman, 1950, Wausau
Dr. F. W. Madison, 1951, 425 East Wisconsin Avenue, Milwaukee 2
Dr. W. S. Bump, 1952, Rhinelander
Dr. K. H. Doege, ex officio, Marshfield
Dr. W. S. Middleton, ex officio, 1300 University Avenue, Madison 6
Dr. J. S. Hirschboeck, ex officio, 561 North Fifteenth Street, Milwaukee 3

The Committee on Tuberculosis and Chest Diseases

Dr. L. O. Simenstad, 1949, chairman, Osceola
Dr. A. A. Pleyte, 1948, 1018 North Jefferson Street, Milwaukee 2
Dr. J. S. Steele, 1950, 1705 West Wisconsin Avenue, Milwaukee

The Advisory Committee to Woman's Auxiliary

Chairman of Council, chairman
Immediate past-president
President
President-elect
Secretary

The Committee on Visual Defects

Dr. J. K. Trumbo, 1950, chairman, 502 Third Street, Wausau
Dr. R. P. Sproule, 1949, 208 East Wisconsin Avenue, Milwaukee 2
Dr. A. H. Pember, 1948, 500 West Milwaukee Street, Janesville

COMMITTEES OF THE PRESIDENT

The Special Committee on Public Welfare and State Departments

Dr. W. A. Munn, chairman, 19 South Main Street, Janesville
Dr. H. H. Christofferson, Colby
Dr. P. R. Minahan, 110 North Washington Street, Green Bay
Dr. B. J. Hughes, Winnebago
Dr. H. E. Cook, 536 West Wisconsin Avenue, Milwaukee 3

Centennial Exposition Committee

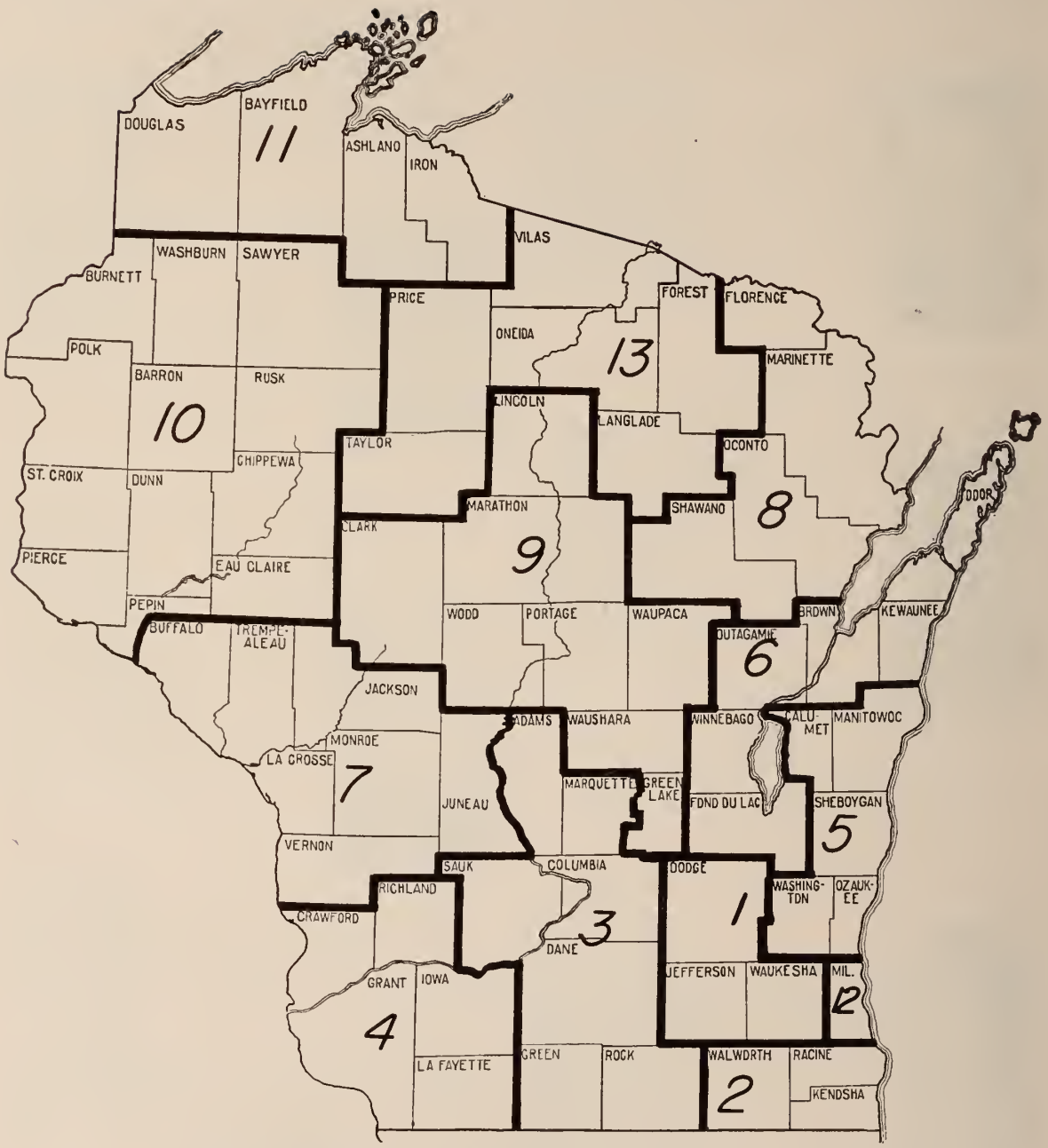
All past-presidents were named to this special committee, and they were charged to appoint a special executive committee to implement the program.

COMMITTEES OF THE COUNCIL

(The personnel of these committees will be appointed by the chairman of the Council at the January Council meeting and will be found in the minutes of that meeting, to be published in a subsequent issue.)

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference on Medical Service will be held at the Palmer House in Chicago on Sunday, February 8, and will feature discussions of important controversial problems affecting medical practice, hospitals, and nursing. At the morning session, opening at 9:30, Everett W. Jones, Chicago, and Dr. Lowell S. Goin, Los Angeles, will discuss "The Practice of Medicine by Hospitals, Health Departments, and Medical Schools"; Dr. L. Fernald Foster, Bay City, Michigan, will speak on "Medical Public Relations Begin in the Doctor's Office"; and Dr. Thomas P. Murdock, Meriden, Connecticut and Janet Geister will review "Nursing Problems in America." The afternoon will be devoted to panel discussion of "General Practice" and "Specialty Boards."



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. J. F. Wilkinson, Oconomowoc

Second District:
Dr. T. C. Hemmingsen, Racine

Third District:
Dr. C. O. Vingom, Madison

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. S. E. Gavin, Chairman
Fond du Lac

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Peshtigo

Ninth District:
Dr. H. H. Christofferson, Colby

Tenth District:
Dr. R. G. Arveson, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. D. H. Witte, Milwaukee
Dr. R. E. Fitzgerald, Milwaukee
Dr. J. W. Truitt, Milwaukee

Thirteenth District:
Dr. J. D. Leahy, Park Falls

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATURE

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies who have been certified to the headquarters of this Society, and whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member. providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

* As amended by the 1947 House of Delegates.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during January for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service and Public Relations.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Medical Education and Hospitals.
A Committee on Medical Economics and Voluntary Sickness Insurance.
A Committee on Maternal and Child Welfare.
A Committee on Health and Public Instruction.
A Committee on Coordination of Medical Services.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Mental Hygiene and Institutional Care.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Industrial Health.
A Committee on Hospital Relations.
A Committee on Cancer.
A Committee on Visual Defects.
A Committee on Hearing Defects.
A Committee on Rural Health and Accident Prevention.

Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, and three years, and thereafter for terms of three years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service and Public Relations shall consist of the chairman of the Council, the president, the past president, the speaker of the House of Delegates, and five members appointed by the president of the Society. Each appointed member shall serve for a term of five years, provided that of the appointments made in 1946, the terms shall be for one, two, three, four and five years as designated by the incoming

president. The Council on Medical Service and Public Relations shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

SEC. 4. The Committee on Public Policy shall consist of three members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

SEC. 7. The Committee on Medical Economics and Voluntary Sickness Insurance shall be charged with the responsibility of reporting annually to the House of Delegates such recommendations as may, in its judgment, seem proper with reference to the subject of medical economics and voluntary sickness insurance. The committee shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years each.

SEC. 8. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 9. The Committee on Health and Public Instruction shall consist of three members. It shall carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates and Council may direct.

SEC. 10. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 11. The Committee on Goiter shall consist of three members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 12. The Committee on Mental Hygiene and Institutional Care shall consist of three members, and its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and to alleviate mental illnesses.

SEC. 13. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 14. The Committee on Tuberculosis and Chest Diseases shall consist of three members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 15. The Committee on Industrial Health shall consist of three members, and its principal duties shall be to cooperate with the Council on Industrial Health of the American Medical Association, and to seek to further the health of those employed in industry in Wisconsin.

SEC. 16. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

SEC. 17. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 18. The Committee on Visual Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 19. The Committee on Hearing Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 20. The Committee on Rural Health and Accident Prevention shall consist of three members and shall engage in activities in promoting health and safety in rural Wisconsin.

SEC. 21. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member who shall have attained his seventy-fifth year and shall have been a member of his county medical society in Wisconsin continuously since beginning the practice of medicine, or who for forty years shall have been continuously a member of his county medical society in Wisconsin shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him annually.

An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses. Affiliate membership shall be on an annual basis only, and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from

the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its Constitution and By-Laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

MEMBERS OF THE "50 YEAR CLUB"

Fifty years is a long time to devote to one job. It is particularly a long time to devote to the active practice of medicine.

In recognition of this fact, the State Medical Society formed a "Fifty Year Club" to honor its members who have served the health of their communities for more than half a century. Seventy-five physicians became charter members of the club at its first meeting in Milwaukee, Oct. 7, 1947. Each received an engraved certificate certifying his eligibility for membership.

Thos. Arneson, Almena
L. H. Baldwin, Gillett
E. C. Barnes, Ripon
J. S. Barnes, Milwaukee
L. W. Beebe, Superior
S. D. Beebe, Sparta
Alfred Belitz, Pepin
A. M. Bodden, Milwaukee
F. F. Bowman, Madison
C. D. Boyd, Kaukauna
H. E. Breckenridge, Waupaca
E. H. Brooks, Appleton
R. C. Buchanan, Green Bay
E. W. Burkhardt, Menomonee Falls
H. O. Caswell, Fort Atkinson
F. G. Connell, Oshkosh
W. W. Crockett, Beloit
G. E. Crosley, Milton
M. A. Cunningham, Janesville
Wilson Cunningham, Platteville
J. S. Cutler, Wauwatosa
R. E. Davies, Waukesha
G. C. Devine, Ontario
J. M. Dodd, Ashland
F. J. Donnelly, North Lake
M. J. Donohue, Antigo
J. H. Doyle, Little Chute
August Doerr, Milwaukee
Arnold Drexel, Wauwatosa
R. C. Faulds, Abrams
G. H. Fellman, Milwaukee
J. J. Fitzgerald, Eagle
Wm. Fitzgibbon, Milwaukee
W. H. Folsom, Fond du Lac
A. E. Gentner, Sheboygan
Mina B. Glasier, Bloomington
A. R. F. Grob, Milwaukee
E. C. Grosskopf, Waukesha
W. E. Ground, Superior
V. A. Gudex, Milwaukee
C. K. Hahn, Racine
F. W. Hammond, Manitowoc
W. C. Hanson, Racine
C. A. Harper, Madison
T. L. Harrington, Milwaukee
C. S. Hayman, Boscobel
G. A. Hipke, Milwaukee
A. T. Holbrook, Milwaukee
H. J. Irwin, Baraboo
H. A. Jegi, Galesville
Joseph Kahn, Milwaukee
G. L. Karnopp, Wautoma
O. E. Lademan, Milwaukee
J. J. Looze, Wisconsin Rapids
R. W. McCracken, Union Grove
T. H. Marsden, Fennimore
E. A. Miller, Clintonville
D. V. Meiklejohn, Fond du Lac
R. C. Montgomery, King
F. H. Munkwitz, Milwaukee
H. J. Orchard, Superior
W. R. Notbohm, Dousman
T. W. Nuzum, Janesville
P. A. Panetti, Hustisford
A. J. Patek, Milwaukee
H. E. Perrin, Star Prairie
E. A. Petzke, Hixton
C. C. Post, Barron
Wm. Reese, Dodgeville
J. S. Reeve, Appleton
W. A. Sickels, South Milwaukee
C. T. Tasche, Sheboygan
J. G. Taylor, Milwaukee
U. J. Tibbits, Waukesha
T. G. Torpy, Minocqua
E. P. Webb, Beaver Dam
M. R. Wilkinson, Oconomowoc
G. H. Williamson, Neenah
W. C. F. Witte, Milwaukee

1947 House of Delegates

Society	*Delegate*	*Alternate*
Ashland–Bayfield–Iron	C. W. Lockhart, Mellen	W. E. Bargholtz, Ashland
Barron–Washburn–Sawyer Burnett	S. O. Lund, Cumberland	O. E. Rydell, Rice Lake
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Krohn, Robert

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Newton, J. E.
Nuebel, C. J.

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Martinetti, D. J.

Hustisford:
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Danforth, H. C.
Donkle, M. J.
Farnsworth, R. W.
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Freitag, S. A.
Gamet, J. H.
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Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
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Overton, O. V.
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Schroder, J. R.
Schroeder, J. D.
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Snodgrass, T. J.
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VanKirk, F. W.
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Reis, G. W.

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Creighton, L. H.
Creswell, C. M.
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DeFazio, S. F.
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Herzog, P. S.
Hill, B. S.
Kappus, H. C.
Kent, L. T.
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Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Pearson, J. B.
Pechous, C. E.
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Pifer, P. E.
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Randall, A. J.
Rauch, A. M.
Rauen, L. M.
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Schwartz, G. J.
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Siegel, Morris
Sokow, Theodore
Stewart, W. C.
Ulrich, C. F.

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Edwards, R. G.

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Nesemann, R. M.
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Nauth, D. F.

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Flynn, R. E.
Fox, J. C.
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Gallagher, F. J.
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Gray, R. H.
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Gundersen, Gunnar
Gundersen, S. B.
Gundersen, T. E.
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Heraty, J. E.
Hulick, P. V.
Johnson, M. A.
Jones, W. J.
Lueck, G. W.
Malin, G. F.
McGarty, M. A.
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Midelfort, C. F.
Mueller, J. J.
Reay, G. R.
Remer, W. H.
Ridout, G. B.
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Brady, C. J.
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MacDonald, W. H.

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Turcott, R. A.

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Matthiesen, D. E.

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Burke, Mead
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Dean, J. L.
Dean, J. P.
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Dollard, J. E.
Domine, A. Z.
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Ellis, I. G.
Erickson, T. C.
Everson, L. K.
Ewell, G. H.

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Harper, C. A.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Hennen, R. J.
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Jackson, J. A.
Jackson, R. H.
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Johnson, H. C.
Johnson, S. A. M.
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Juster, E. M.
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Kurtz, E. C.
Lacke, C. L.
Larsen, R. B.
Lemmer, K. E.
Leonard, T. A.
Lindsay, W. T.
Littig, L. V.
Longley, B. J.
Lorenz, W. F.
Lubing, H. N.
Ludden, R. H.
Mailer, A. R.
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Miller, W. C.
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Moore, W. J.
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Sherman, C. F.
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Sisk, I. R.
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
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Sullivan, E. S.
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Wear, J. B.
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Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Wilkie, J. M.
Williams, D. L.
Winn, H. N.
Wirig, M. H.
Wirka, H. W.
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Youngreen, H. C.

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Radl, C. J.
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Rauch, W. A.
Rees, T. H.
Scherping, W. H.
Simenson, R. S.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
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Jorgenson, H. L.
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May, J. V.
Moss, K. J.
Mudge, W. A., Jr.
Nadeau, A. T.
Pinegar, K. G.
Rogers, R. J.
Schroeder, H. F.
Shaw, R. W.
Simms, D. M.
Zeratsky, J. D.

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Van Schaick, R. E.
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Markesan:
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Pelton, R. S.

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Boeckman, F. A.
Christofferson, J. W.
Copps, L. A.
Custer, G. S., Jr.
Doege, K. H.
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Epstein, S. E.
Hipke, Wm.
Lewis, R. F., Jr.
Macauley, W. L.
Mason, R. W.
McCormick, G. L.
McGinn, E. J.
Miliard, A. L.
Miller, G. E.
Potter, R. P.
Vedder, C. A.
Vedder, J. B.
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Wickham, J. M.
Wink, R. H.

Mattoon:
Partridge, O. F.

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Hess, J. S.
Vedner, J. H.

Mayville:
Bachhuber, F. G.
Holland, H. J.
Parish, G. A.

Mazomanie:
Schultz, I.

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Elvis, E. B.
Norton, D. M.
Nystrum, L. E.
Nystrum, R. C.

Melien:
Lockhart, C. W.

Melrose:
Lavine, I. H.

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Foseid, O. F.
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Jensen, F. G.
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Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.
Shemanski, L. S.

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Remley, A. R.
Sauthoff, August

Menomonee Falls:
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Domann, W. G.
Hoyt, G. E.
Schloemer, A. J.

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Buckley, C. H.
Grannis, I. V.
Halgren, J. A.
Long, D. T.
Lumsden, Wm.
McMahon, A. E.
O'Neill, J. W.
Quilling, P. A.
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Steves, B. J.

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Anderson, W. A. D.
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Arneth, J. J.
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Ausman, D. C.
Ausman, H. R.
Avellone, B. M.
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Bach, E. C.
Bach, M. J.
Bach, R. J.
Bachhuber, E. A.
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Backus, E. A.
Baier, A. R.
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Baldigo, E. M.
Bardenwerper, H. E.
Barnes, J. S.
Barrock, J. J.
Barta, E. F.
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Benton, R. W.
Bercey, J. E.
Bergmann, G. J.
Bernhard, L. A.
Bernhart, E. L.
Beutler, A. D.
Bickler, E. P.
Biller, J. H.
Biller, S. E.
Birge, E. A.
Black, S. B.
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Blanchard, H. H.
Blankstein, S. S.
Blount, W. P.
Blumenthal, R. W.
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Bornstein, S. L.
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Brand, W. D.
Brazy, R. R.
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Casper, W. T.
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Conway, J. P.
Cook, E. F.
Cook, H. E.
Coon, W. L.
Corcoran, C. J.
Correll, H. L.
Cowan, I. I.
Cox, J. A.
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Devitt, J. S.
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Dunst, C. G.
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Eisenberg, J. J.
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Eisenberg, P. J.
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Fechter, F. R.
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Fitzgerald, R. E.
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Foerster, O. H.
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Fox, M. S.
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Franklin, I.
Franklin, S. N.
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Gramling, J. J.
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Greenthal, R. M.
Greenwalt, T. J.
Griffith, J. C.
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Gudex, V. A.
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Gute, E. B.
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Guzzetta, M. M.
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Habbe, J. E.
Habeck, E. A. W.
Haberland, J. E.
Haessler, F. H.
Hake, C. B.
Hall, R. M.
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Hankwitz, A. W.
Hansen, A. C.
Hansen, H. T.
Hansen, J. W.
Hansher, Ervin
Hausmann, G. H.
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Hardgrove, Maurice
Hardy, C. F.
Hargarten, L. W.
Harper, C. W.
Harrington, E. T.
Haug, J. F.
Haukohl, R. S.
Haushalter, H. P.
Haushalter, L. E.
Hausmann, P. F.
Headlee, C. R.
Heeb, H. J.
Heen, R. C.
Hefke, H. W.
Heidner, F. C.
Heifetz, E. C.
Heil, J. V.
Heipp, E. A.
Heise, H. A.
Heller, T. A.
Henes, Edwin Jr.
Heraty, J. A.
Hermann, A. H.
Herner, W. L.
Hertel, A. J.
Herzog, J. V.
Higgins, S. G.
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Hilger, W. A.
Hill, F. A.
Hiller, R. I.
Hiller, S. J.
Hipke, G. A.
Hipke, L. W.
Hipke, M. M.
Hirschboeck, J. S.
Hitz, J. B.
Hoermann, B. A.
Hofmeister, F. J.
Holbrook, A. A.
Holbrook, A. T.
Hollenbeck, S. W.
Hood, A. J.
Hornberger, E. Z.
Houghton, W. J.
Hovis, W. F., Jr.
Howard, T. J.
Huber, H. H.
Hultman, C. A.
Hume, W. W.
Hurwitz, S. P.
Huston, John
Huth, E. P.
Imp, J. F.
Irwin, R. S.
Jaastad, L. B.
Jackson, Edward
Jacobson, E. B.
Jahn, R. P.
James, L. J.
Jefferson, R. A.
Jekel, J. M.
Jelenchick, E. J.
Jenner, J. A.
Jermain, W. M.
Jochimsen, M. A.
Johnson, A. W.
Johnson, Frances
Johnson, H. W.
Johnson, J. H.
Johnston, R. C.
Johnston, T. L.
Jones, W. L.
Jorgenson, E. F.
Jorgensen, P. B.
Judge, T. A.
Jurgens, G. H.
Jurishica, A. J.
Jurss, C. D.
Kahn, Joseph
Kalb, C. H.
Kane, A. M.
Karen, Robert
Karr, J. K.
Kassowitz, K. E.
Kastner, A. L.
Kaufman, L. W.
Kay, E. M.
Kearns, W. M.
Kelly, G. F.
Kendall, T. E.
Kettelhut, E. J.
Kiley, W. E.
Kilian, A. D.
Kilkenny, G. S.
King, J. J.
King, J. M.
Klnsey, J. L.
Kissinger, C. A.
Kissling, A. C.
Klein, J. T.
Kleinboehl, J. W.
Kleis, W. J.
Klopfer, W. P.
Klumb, M. G.
Knudson, A. H.
Koch, M. J.
Kocovsky, E. C.
Kohn, S. E.
Kores, V.
Kovacs, Arthur
Kozina, F. J.
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Kramoris, F. H.
Krembs, M. A.
Kretchmar, L. H.
Kretchmar, Morris
Kretlow, F. A.
Krlstjanson, H. T.
Kritter, F. J.
Kriz-Hettwer, Rose
Krumbiegel, E. R.
Kruszewski, J. L.
Krygier, A. A.
Krygier, A. J.
Krygier, W. L.
Krzysko, S. L.
Kuhn, H. J.
Kuhn, M. J.
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Lademan, O. E.
Ladewig, A. W.
Ladewig, H. C.
Lahmann, A. H.
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Langjahr, A. R.
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Lee, P. A.
Leitch, G. W.
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Levin, A. J.
Levine, Abram
Lewis, Marian
Lieberman, Benj.
Liefert, W. C.
Light, George
Lindert, M. C. F.
Lobedan, E. T.

Lochman, D. J.
Long, C. W.
Lotz, Oscar
Love, I. B.
Lungmus, B. A.
Lustok, M. J.
Maas, D. W.
Macht, A. J.
MacKedon, W. L.
Mackoy, F. W.
MacRae, M. F.
Madison, F. W.
Madison, J. D.
Maercklein, O. W.
Malloy, T. G.
Malnekoff, B. J.
Mann, R. W.
Manning, H. J.
Margolies, F. C.
Margoles, Milton
Marks, J. L.
Markson, L. S.
Markson, S. M.
Marlewski, C. R.
Marquardt, C. R.
Martens, E. W.
Martin, A. G.
Martin, H. G.
Martineau, E. L.
Mason, E. W.
Mateicka, P. J.
Maxwell, H. P.
Maylahn, D. J.
McBeath, N. E.
McCabe, John
McCabe, J. O.
McCann, Edith
McCanna, P. R.
McCarty, R. T.
McCormick, D. W.
McCormick, T. F.
McDonald, C. F.
McDonald, R. E.
McKittrick, N. W.
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Mensing, E. H.
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Merten, P. J.
Messmer, C.
Meyer, B. J.
Miller, E. W.
Miller, H. L.
Miller, L. E.
Millington, P. E.
Miner, D. L.
Miner, H. B.
Mitchell, S. R.
Molsberry, J. M.
Montgomery, A.
Montgomery, R. P.
Mookerjee, M. K.
Moore, G. E.
Morgan, J. E.
Morgan, S. F.
Morter, R. E.
Morton, S. A.
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Mueller, Nina T.
Muenzer, R. J.
Mufson, J. A.
Mulsow, J. E.
Murphy, F. D.
Murphy, J. A.
Murphy, W. J.
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Nelson, J. D.
Nelson, W. V.
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O'Connor, R. D.
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Oswald, Frederick
Ottenstein, H. H.
Ovitt, D. W.
Owen, G. C.
Owen, J. D.
Oxman, E. M.
Ozonoff, J. B.
Pallasch, F. J.
Panetti, H. E.
Paquette, L. J.
Park, C. F.
Parks, S. L.
Patek, A. J.
Paulbeck, T. M.
Peelen, A. W.
Pegram, J. W.
Pendergast, T. J.
Perlson, P. H.
Pessin, S. B.
Peterman, M. G.
Peters, B. J.
Peters, L. M.
Peterson, F. N.
Pfeffer, E. N.
Pfeffer, T. J.
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Piaskoski, R. G.
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Rabin, Allen
Raine, Forrester
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Regan, J. M.
Regan, J. R.
Reifenrath, I. B.
Reinke, C. C.
Rettig, E. H.
Reuter, M. J.
Reynolds, J. H.
Rheineck, A. F.
Ricciardi, I. J.
Rice, E. L.
Rice, E. M.
Rice, R. L.
Rich, G. J.
Richardson, R. C.
Riehl, F. W.
Rife, C. S.
Rikkers, D. F.
Ritchie, Gorton
Robbins, J. M.
Roberts, D. W.
Robinson, H. P.
Roby, H. S.
Roethke, R. W.
Rogers, C. E.
Rogers, E. H.
Rogers, M. F.
Rolfs, T. H.
Ronneburger, E. O.
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Rosenbaum, M. K.
Rosenberg, S. W.
Rosenberger, A. I.
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Ross, F. A.
Rothman, L. E.
Rotter, E. J.
Rowan, J. P.
Royce, Owen, Jr.
Ruch, D. M.
Rueth, J. E.
Ruppenthal, A. J.
Ruschhaupt, L. F.
Ruskin, B. A.
Russell, R. J. M.
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Ryan, P. W.
Ryan, W. A.
Sadoff, H. B.
Sagi, J. H.
Sakaguchi, Shimpei
Saketos, T. P.
Salinko, S. S.
Salinsky, L. V.
Sander, O. A.
Sanders, R. H.
Sanfelippo, A. J.
Santer, D. G.
Sargent, J. C.
Sass, L. C.
Savage, G. T.
Schacht, W. J.
Schade, R. E.
Schaefer, A. A.
Schelble, E. J.
Schelble, J. P.
Schlaepfer, K.
Schlomovitz, B. H.
Schlomovitz, E. H.
Schlomovitz, H. H.
Schlueter, U. A.
Schmidt, A. C.
Schmidt, E. J.
Schmidt, H. G.
Schmit, Felix
Schmit, Louis
Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
Schneider, C. R.
Schneider, C. S.
Schodron, R. C.
Schoen, C. M.
Schoenkerman, B. B.
Scholter, E. A. W.
Schoofs, O. P.
Schowalter, R. P.
Schramel, A. J.
Schroeder, C. M.
Schroeder, H. T.
Schroeder, I. L.
Schroeder, J. C.
Schubert, F. J.
Schuenzel, L. G.
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Schulz, Irwin
Schumacher, H. S.
Schumm, H. C.
Schuster, Myron
Schutte, A. G.
Schwade, E. D.
Schwade, L. J.
Schwartz, A. B.
Schwartz, G. R.
Schwartz, S. F.
Schweiger, L. R.
Schweitzer, G. J.
Schweitzer, W. A.
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Seegers, F. W.
Seelman, A. G.
Seelman, J. J.
Selle, F. S.
Senn, Ulrich
Servis, L. T.
Shaiken, Joseph
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Shapiro, A. M.
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Silber, E. N.
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Smith, L. D.
Smits, R. H.
Smuckler, R. H.
Solberg, M. E.
Spitz, M. M.
Spooner, A. D.
Sproule, R. P.
Squier, T. L.
Stamm, L. P.
Stark, R. M.
Steele, J. D., Jr.
Stefanez, J. S.
Stein, Wm.
Steiner, C. M.
Stocklnger, R. E.
Stoddard, F. J.
Stone, J. R.
Stouffer, J. G.
Strass, H. W.
Stratton, F. A.
Straus, G. D.
Studley, W. H.
Sullivan, G. A.
Sullivan, J. M.
Sverdlin, A. A.
Swartz, L. W.
Sweet, S. J.
Szymarek, J. E.
Tabachnick, H.
Tallmadge, G. K.
Tashkin, E. H.
Tauber, L. J.
Taugner, V. J.
Tax, A. H.
Taylor, J. G.
Tegtmeyer, G. F.
Temple, J. W.
Teschan, R. A.
Tessier, A. F.
Thanos, J. N.
Tharinger, E. L.
Thatcher, D. S.
Thill, G. E.
Thoma, J. W.
Thomas, C. O.
Thompson, F. A.
Thompson, R. D.
Thorstensen, A. H.
Thranow, J. A.
Tillson, E. M.
Toenhart, O. E.
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Torcivia, S. S.
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Trimborn, B. A.
Truitt, J. W.
Tuft, W. R.
Tufts, Millard
Turney, C. F.
Uhley, M. H.
Urdan, B. E.
Usow, E. J.
Usow, J. M.
Uszler, L. B.
Vaccaro, J. E.
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Vander Linde, L. A.
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Verch, L. H.
Verdone, A. J.
Vogl, H. L.
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Wagner, P. C.
Waldeck, E. A.
Waldman, I. J.
Walker, L. J.
Walske, B. R.
Walton, W. B.
Warner, R. C.
Warschauer, B.
Warth, C. G.
Washburn, R. G.
Wasserman, S. E.
Watts, Alice D.
Waxman, S. I.
Weber, A. J.
Weber, J. E.
Weber, M. L.
Wegmann, G. H.
Wegmann, N. J.
Weil, H. R.
Weingart, W. F.
Weinshel, L. R.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, L. A.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Wendt, W. P.
Wenstrand, D. E. W.
Werbel, H. J.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Wiener, Kurt
Wiese, M. E. J.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Wilkinson, P. M.
Willson, D. M.
Wilske, C. A.
Wilson, A. C.
Winnemann, W. J.
Wirthwein, Carlton
Witte, D. H.
Wolter, S. H.

Wolters, H. F.
Wong, V. J.
Worm, G. J.
Wright, H. H.
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Yaffe, Aaron
Yanke, A. E.
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Young, A. F.
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White, C. L.

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Sprague, J. P.
Torpy, T. G.

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Skwor, C. J.

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Sharp, D. S.
Walker, J. P.

Monroe:
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Gnagi, W. B., Jr.
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Marbry, G. W.
Mings, D. E.
Moore, L. A.
Rence, W. G.
Ruehlman, D. D.
Schindler, J. A.
Snowden, P. W.
Weir, J. R.

Montello:
Inman, R. F.

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Pierpont, J. M.

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Miller, J. F.

Mount Horeb:
Helland, N. J.
Morrison, M. T.

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Kern, E. E.
Purdy, F. P.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.

Neenah:
Anderson, G. R.
Axley, A. W.
Baxter, H. L.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Lowe, R. C.
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Smith, F. H.
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Smith, T. D.
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Overman, M. V.
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Rosekrans, Sarah D.

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Backus, O. A.
Pomainville, H. G.
Werner, W. A.

Neosho:
Lehman, R. H.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Starnes, Brand

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Drury, E. M.
Epley, O. H.

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McCormack, E. A.

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Allen, J. S.

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Loughnan, A. J.
Love, G. R.
Nammacher, T. H.
Peters, H. A.
Rogers, A. F.
Stemper, I. T.
Taylor, C. W.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
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Wilkinson, M. R.

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Slaney, A. F.

Oconto Falls:
Goggins, R. J.
Krahn, G. W.
Rauchschwalbe, L. E.
Robinson, T. N.

Ogema:
Rinehart, B. M.

Okauchee:
Loughlin, D. M.

Omro:
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Ontario:
Devine, G. C.

Oostburg:
Van Driest, J. J.

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Johnson, E. S.
Joyner, T. H.

Orfordville:
McNair, E. R.

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Danforth, Q. H.
Ebert, R. O.
Emrich, P. S.
Haines, M. C.
Haubrick, H. J.
Helmes, L. O.
Hogan, J. M.
Hugo, D. G.
Kleinschmit, H. W.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Meilicke, C. A.
Meli, J. V.
Mendez, A. A.
Meusel, H. H.
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Steele, G. A.
Steen, M. H.
Stein, J. F.
Strauser, E. R.
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Wagner, W. A.
Wheeler, W. P.
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Gillette, H. E.
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Pepin:
Belitz, A. E.
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Bell, J. M.
Haasl, H. W.

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Kelly, J. P.

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Schmitt, R. W.

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Rens, J. L.
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Beyer, Hart

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Plainfield:
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Bigford, W. D.

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Principles of Medical Ethics of the American Medical Association

CHAPTER I

IN GENERAL

THE PHYSICIAN'S RESPONSIBILITY

SECTION 1.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

GROUPS AND CLINICS

SEC. 2.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS

PATIENCE, DELICACY AND SECRECY

SECTION 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 2.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

PATIENTS MUST NOT BE NEGLECTED

SEC. 3.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLD HONOR OF PROFESSION

SECTION 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

MEDICAL SOCIETIES

SEC. 2.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

DEPORTMENT

SEC. 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty

without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

ADVERTISING

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

PATENTS AND PERQUISITES

SEC. 5.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

MEDICAL LAWS—SECRET REMEDIES

SEC. 6.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

SAFEGUARDING THE PROFESSION

SEC. 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighboring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III.—DUTIES OF PHYSICIAN IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

PUNCTUALITY

SEC. 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant

or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO SPECIALIST

SEC. 4.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

ATTENDING PHYSICIAN RESPONSIBLE

SEC. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the

practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

RELINQUISHING PATIENT TO REGULAR ATTENDANT

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

SUBSTITUTING IN OBSTETRIC WORK

SEC. 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

CONTRACT PRACTICE

SEC. 3.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined

to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

COMMISSIONS

SEC. 4.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

DIRECT PROFIT TO LAY GROUPS

SEC. 5.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

THE DUTIES OF THE PROFESSION TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

PUBLIC WARNED

SEC. 3.—Physicians should warn the public against the devices practiced and the false pretentions made by charlatans which may cause injury to health and loss of life.

PHARMACISTS

SEC. 4.—By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

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*Dolkart, R. E.; Dentler, M., and Barrow, L. L.: The Effect of Various Types of Therapy in the Management of the Irritable Bowel Syndrome. Illinois M. J. *90*:287 (Nov.) 1946.

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2. File a Social Security form quarterly just as in past years. Not later than January 31, 1948, you must file the return for the quarter ending December 31, 1947, and pay the employment tax due for that quarter.
3. The withholding tax, or tax withheld from the income of your subject employes, is due January 31 to cover the last quarter of 1947. It is due on April 30 for the first quarter of 1948, on July 31 for the second quarter, and on October 31 for the third quarter. On January 31 you must file a list of your employes and the amounts paid to them in salaries and the amounts withheld during 1947.
4. The first quarterly estimate of your own income for 1948 is due on March 15. Further estimates are due on June 15, September 15, and January 15. On those dates you may also amend your March estimate.
5. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1948. You are subject to penalties for overlooking either the registration or the tax.

Annual Registration:

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January, 1948. This registration will be on a form furnished by the Board of Medical Examiners.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.
3. If you have changed the address or place of residence or professional office or shall have opened an additional office after your annual registration in January, 1947, you must, within 30 days thereafter, notify the Board of Medical Examiners in writing of such change.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 113.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (6), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness". This is required by a 1947 law.
6. Report *immediately* the following deaths, as required by another 1947 law, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

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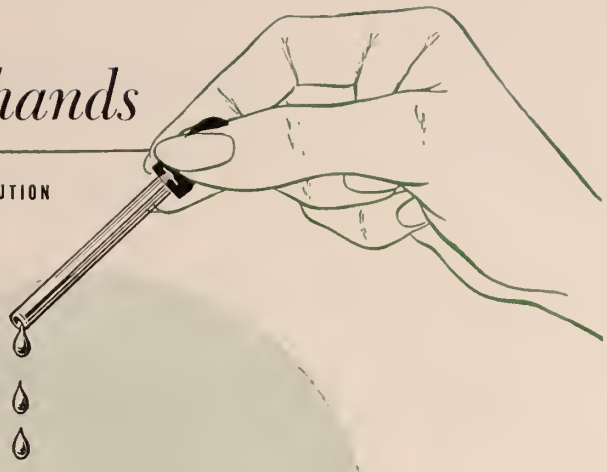

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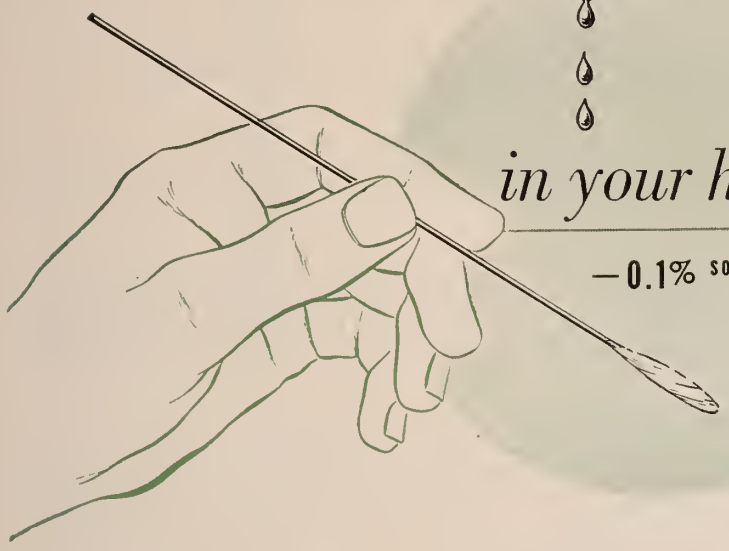

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STATE OF WISCONSIN

No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

Conrad Shearer — Vernon W. Thomson

PRESIDENT PRO TEMPORE OF THE SENATE. SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — Arthur L. May

CHIEF CLERK OF THE SENATE. CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.

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Wausau, St. Mary's Hospital
West Bend, St. Joseph's Hospital
Wild Rose, Wild Rose Hospital

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Rehabilitation Through Better Nutrition: University of Cincinnati Studies in Nutrition at the Hillman Hospital, Birmingham, Alabama. By Tom D. Spies, M. D. Pp. 94, with 50 illustrations. Philadelphia and London: W. B. Saunders Company, 1947.

This small volume is presented as an "exposition of practical therapeutics" stemming from the findings of the so-called "Birmingham Study." In this study some 10,000 individuals were examined by the usual clinical and laboratory methods employed in nutrition surveys of some few years ago. One-half of this group was found to have evidence of nutritive failure. Eight hundred and thirty-nine of this group were selected for follow-up study after therapy was instituted. The goal of therapy, according to the author, was the regaining and maintenance of good health. In spite of the admission by the author as to the difficulties in establishing deficiency states, considerable enthusiasm is expressed by Spies as to the effectiveness of diagnosis and therapy in this study. Apparently one of the main points established in this study is that patients with primary deficiency diseases will get well if they are fed an adequate diet for a sufficiently long period of time, a position which, in the reviewer's opinion, has never been seriously questioned.

The signs and symptoms stated to be associated with the different deficiency states are presented and occupy about one-half of the book's pages. A few photographs of advanced lesions are of interest. On the whole, the data presented are few and difficult to evaluate. The discussion by the author includes a great deal of enthusiasm and uncritical reasoning. It is significant, perhaps, that the appended list of references consists exclusively of publications by Spies and co-workers.—P.P.C.

Diseases of the Chest; with Emphasis on X-Ray Diagnosis. By Eli H. Rubin, M. D., F.A.C.P., F.C.C.P., Attending Physician, Division of Pulmonary Diseases, Montefiore Hospital and Country Sanatorium, New York; Visiting Physician in Tuberculosis and Physician-in-Charge, Chest Clinic, Morrisania City Hospital, New York. Pp. 685, with 355 illustrations (24 plates in color). Philadelphia and London: W. B. Saunders Company, 1947. Price $12.00.

This book differs from the usual clinical monograph on disease of the chest in that roentgenologic findings are stressed and the value of physical signs minimized.

The book is divided into six sections. Section I deals with anatomy, roentgenology, and applied physiology. Section II covers the acute and chronic pneumonias, including a chapter on treatment with sulfonamides and antibiotics. Section III is devoted to pulmonary tuberculosis and its complications. Section IV comprises a discussion of various chronic pulmonary diseases in which the bronchi play a prominent role. Section V includes diseases of the mediastinum, pleura, and diaphragm. Section VI deals with the principles of surgical treatment of chest diseases.

(Continued on page 166)

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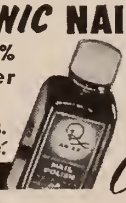
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Throughout the book the author emphasizes the importance of roentgen examination in diagnosis, and most of the illustrations are reproductions of roentgenograms. He remarks that, "Physical diagnosis, as it is generally taught, applies to advanced stages of lung disease. Some of the 'classical' signs have been shown to be incorrect; many are seldom demonstrable, and the value of the few remaining is often debatable." In keeping with this, the description of physical signs is reduced to a minimum. Although roentgen examination is emphasized, this is not a textbook of roentgen diagnosis of chest diseases. Hence descriptions of roentgenologic changes necessarily are brief. Symptoms and signs, pathology, and treatment remain as prominent features. Correlation of clinical and radiologic aspects generally is good, and it is in this field that the chief value of the book lies. It should prove of interest not only to clinicians who wish to obtain a knowledge of the fundamentals of roentgen diagnosis but also to roentgenologists who may wish to attain greater insight into the clinical and pathologic aspects of disease.—L.W.P.

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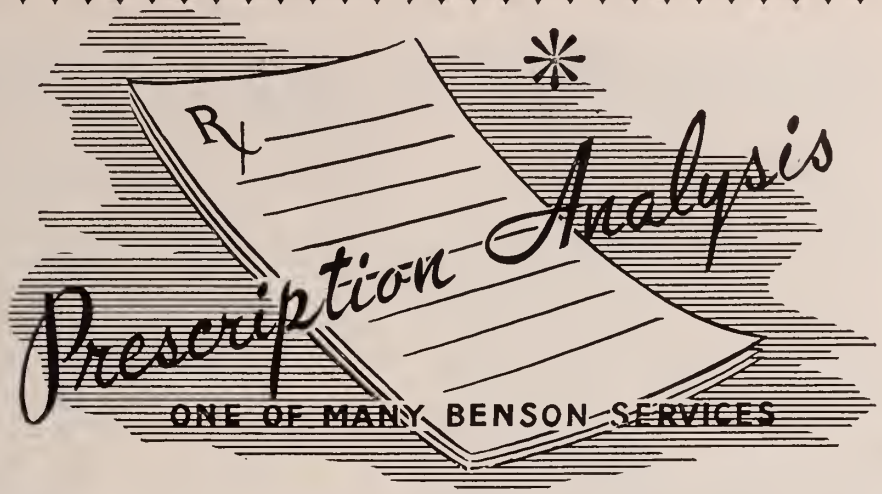

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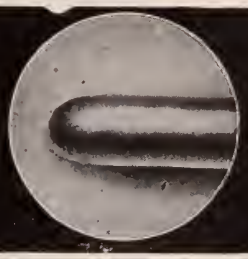

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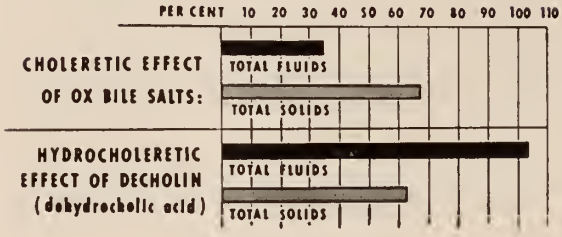

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	32
American Meat Institute	24
American Optical Company	25
Ar-Ex Cosmetics, Inc.	164
Ames Company, Inc.	172
Audiphone Utilities	171
Ayerst, McKenna & Harrison, Ltd.	19
Barlow–Maney Laboratories, Inc.	18
Barr X-Ray Company	169
Benson Optical Company	167
Bergmann Prescription Center	165
Bilhuber–Knoll Corporation	30
Borden Company	161
Burroughs Wellcome and Company	23
Camel Cigarettes	21
Camp, S. H. and Company	20
Central Drug	166
Chicago Medical Society	30
Ciba	159
Cook County Graduate School of Medicine	169
Doerflingers	166
Drekmeier Drug	165
First Central Dispensary	165
Hotel Schroeder	5
House of Bidwell	169
Hurley X-Ray Company	171
Ivanhoe Treatment, Inc.	175
Jensen Brothers Prescriptions	166
Kennedy–Mansfield	170
Lilly, Eli and Company	facing page 35
Lov-é Brassieres	28
Luzier's Cosmetics, Inc.	16
M & R Dietetic Laboratories	31
Mallatt Pharmacy	165
Mather Pharmacy	166
Mayer Drug	166
Mead Johnson and Company	17, 174
Medical Protective Company	15
Milwaukee Optical Company	34
Milwaukee Sanitarium	176
National Drug Company	33
Nechin, A. R. Company	29
New World Life Insurance Company	165
New York Polyclinic	171
Orthopedic Appliance Company	171
Page Milk Company	14
Parke Davis and Company	2, 3
Philip Morris	13
Physicians and Hospitals Supply Co.	8
Physicians Casualty Association	5
Physicians Radium Association	171
Pine-Aire Lodge	157
Pogue, Mary E. School	169
Prescription Pharmacy	165
Radium Emanation Corporation	167
Radium Service Corporation	169
Rennebohms	165
Rentschlers	170
Rexair	11
Rexall	12
Riggs Optical Company	163
Rogers Memorial Sanitarium	176
Sacred Heart Sanitarium	163
St. Croixdale Sanitarium	5
Schlintz Bros. Drug Store	166
Searle, G. D. and Company	155
Shorewood Hospital Sanitarium	157
Smith–Dorsey Company	26
Smith, Kline and French	10
Squibb	9
Summit Hospital Sanitarium	25
Uhlemann Optical Company	6
Winthrop–Stearns, Inc.	22
Wyeth	27
Zemmer Company	162

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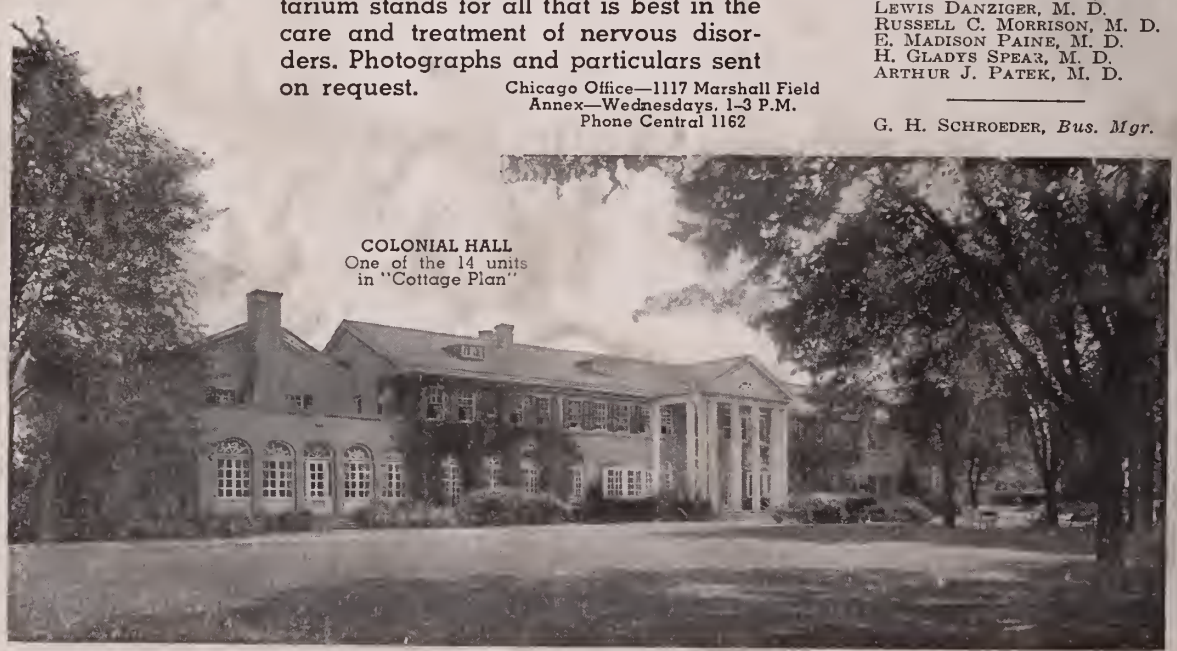

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COMMENTS ON TREATMENT

TABLE OF CONTENTS, PAGE 180

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Trends in Infant Feeding, by Milton J. E. Senn, M. D., New York	195
Notes on the Treatment of Chronic Hepatic Disease, by Albert M. Snell, Rochester, Minnesota	199
The Management of the Allergic Child, by Howard J. Lee, M. D., Milwaukee	204
Fracture Disabilities, by Merritt L. Jones, M. D., Wausau	207
Present Status of Pulmonary Resection for Carcinoma and Inflammatory Diseases of the Lung, by J. W. Gale, M. D., and A. R. Curreri, M. D., Madison	210
Comments on Treatment	214
Notes on Clinical Pathology	218
As It Looks to Your State Board of Health	219

EDITORIAL

	Page
The Spotlight on Research	217

MISCELLANY

	Page
The President's Page	215
Important New Cancer Form Provided	220
Counties Plan In-Plant Industrial Health Clinics	223
Society Proceedings	224
News Items and Personals	230
And About the Third and Twelfth Councilor Districts	234
Society Records	238
Marriages	240
Births	240
Deaths	241
The Woman's Auxiliary	246
The Journal Bookshelf	250
Coming Events	256
Trade News	260
Index to Advertisers	263
Physicians' Exchange	264
List of Executive Officers of County Medical Societies	265

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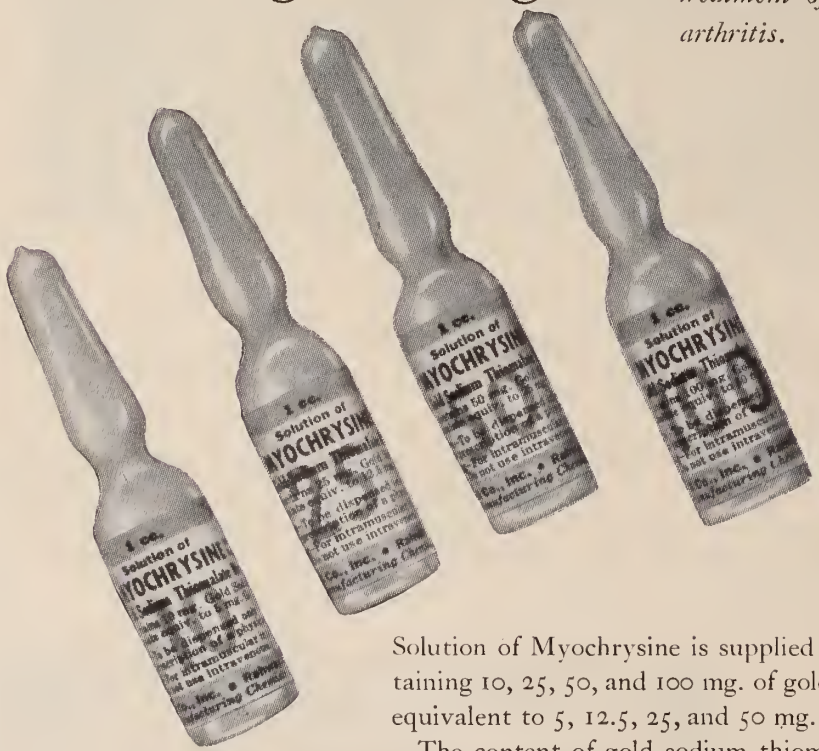

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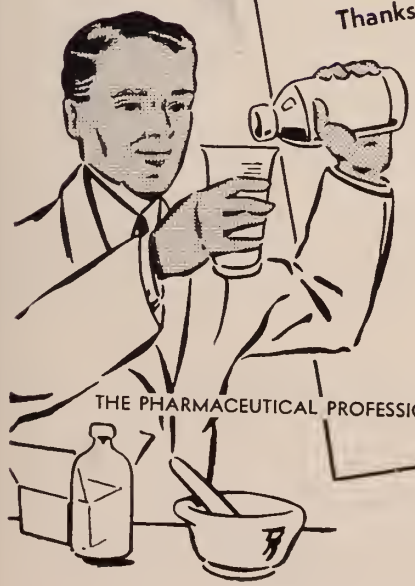

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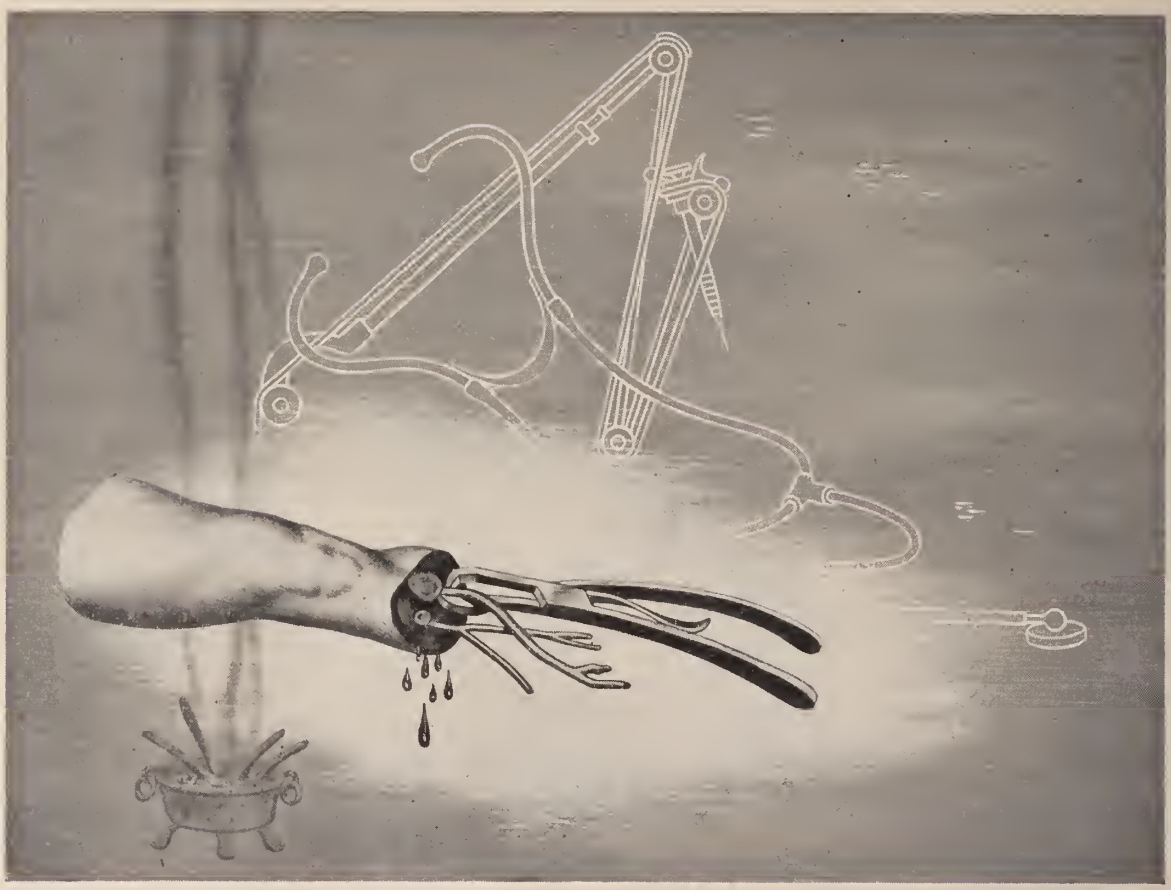

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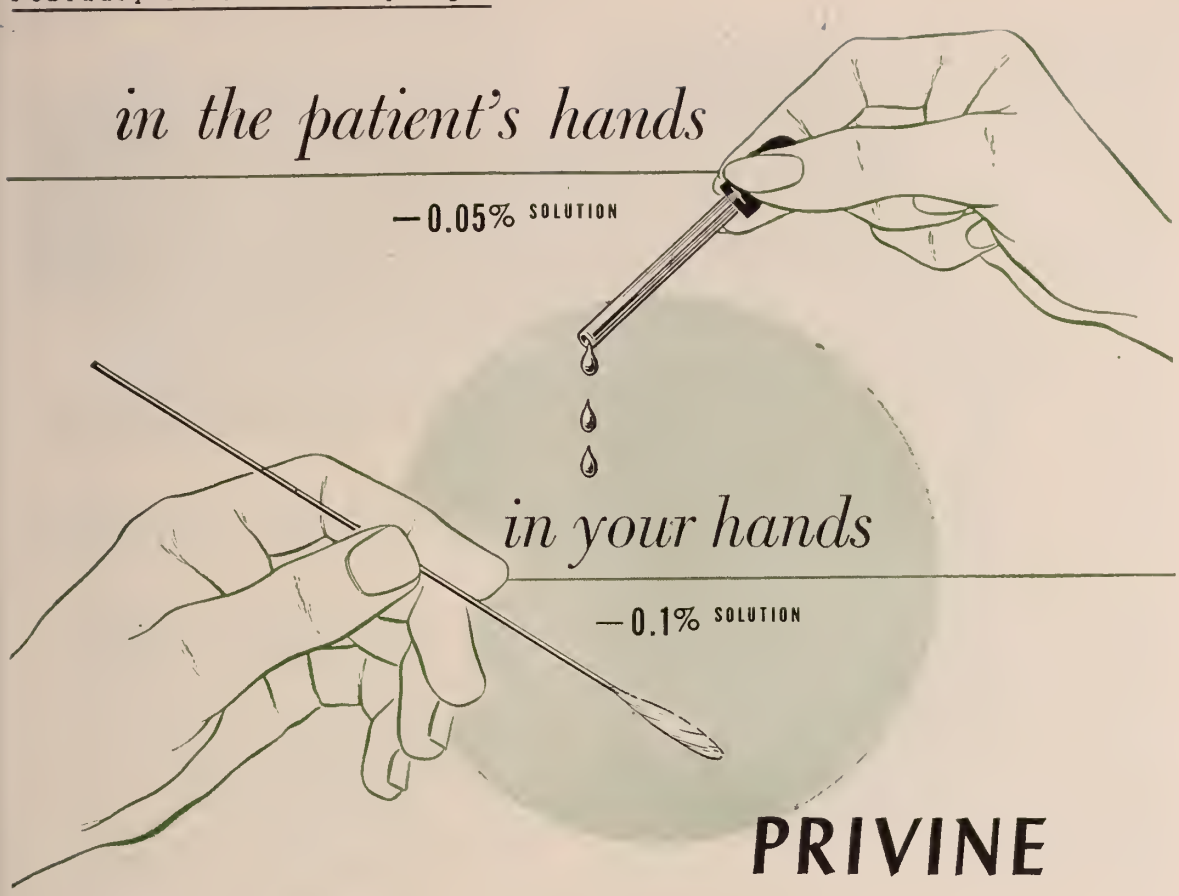

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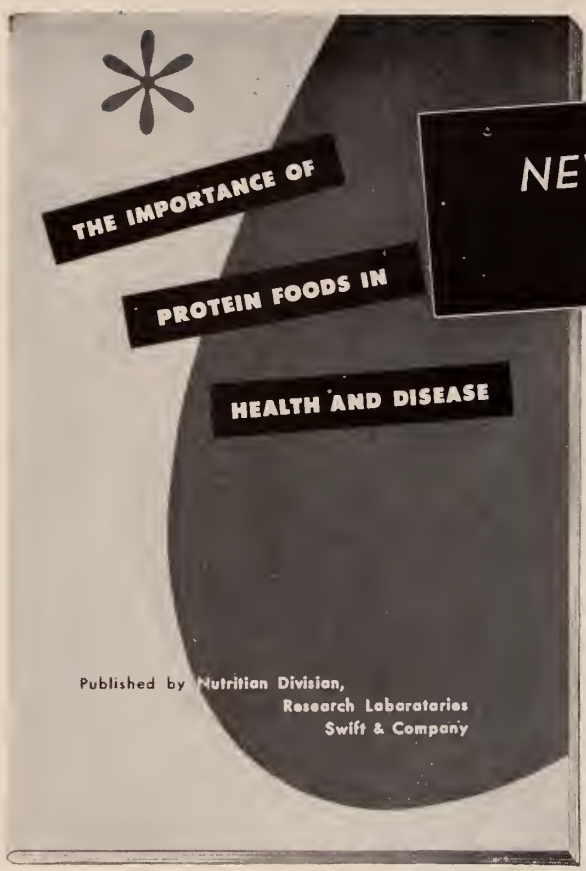

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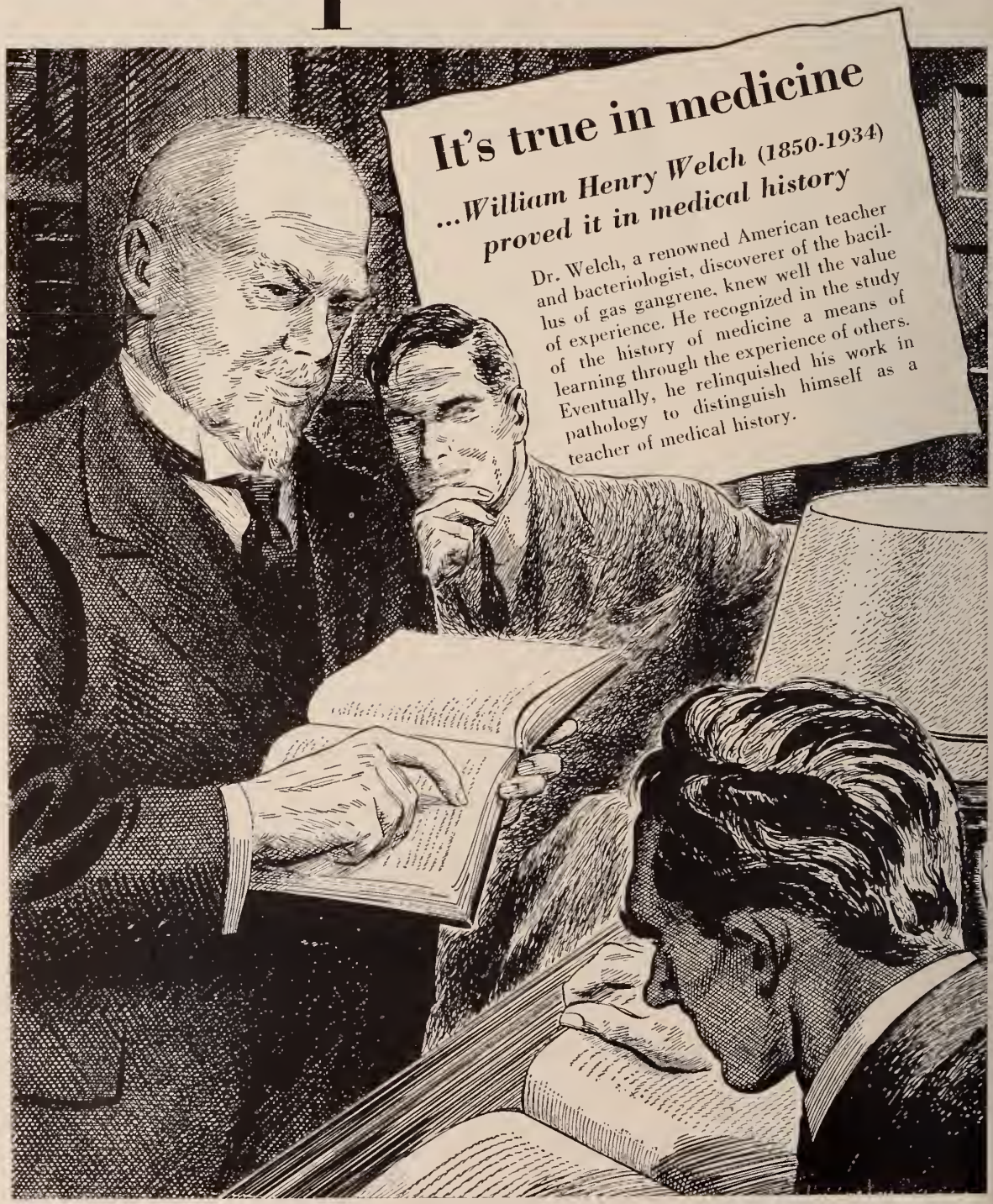

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THE WISCONSIN MEDICAL JOURNAL

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Trends in Infant Feeding*

By MILTON J. E. SENN, M. D.
New York

M. J. E. SENN

A native of Milwaukee, Doctor Senn graduated from the University of Wisconsin Medical School in 1927. He practiced in Milwaukee for a time, going to Washington University School of Medicine, St. Louis, in 1929 as a fellow in pediatrics. Since 1933 he has been associate professor of pediatrics in psychiatry at Cornell University Medical College. He is also attending pediatrician at New York Hospital and is director of the Institute of Child Development.

WHENEVER an attempt is made to describe tendencies or movements, one runs into hazards, for a discussion of trends includes some degree of prediction, and prediction is easily weighted with personal bias. The prophet must ever be mindful of wishful thinking. This paper is not to be considered a prophetic pronouncement, but rather an appraisal of pediatric literature and opinion tinged with personal experiences in the fields of pediatrics and psychiatry. Mindful of the dangers, an attempt will be made to keep this account as objective and impersonal as possible. This paper will deal only with the development of practices in this country.

Trends are dependent on many different factors and circumstances; they do not originate in isolation; they must be considered always in relation to other events. Some of the more usual determinants of trend origin and direction are physical, psychologic, social, economic, and cultural elements working singly or in combinations. Many times similar trends start contemporaneously at distant places, seemingly quite independent of each other.

Breast Feeding

For example, one of the trends in infant feeding at the present time is interest in breast feeding. This technic, once the commonly accepted one of feeding babies, gradually went out of fashion, paralleling in this regard the advance of scientific pediatrics, particularly the refinement and simplification of cow's milk formulas, and coinciding in our country with what has been called the "emancipation of woman" from household and child-care "servitude." Science and cultural forces working together, with a mixture of psychologic influences, lowered the incidence of breast feeding in the past twenty-five years to a point where it has seemed that the human female might regress biologically to the state of a nonlactating mammal. Recently this downward trend seems to have been arrested, the change of its course being less evident in our country, or at least in certain parts of our country, than in some of the European territories. In England breast feeding became a necessity during the last war because of the great lack of cow's milk. We are told by Moncrieff, one of Great Britain's leading pediatricians, that the incidence of breast feeding in England is continuing high in the post-war period, not only because of a continued deficiency of food but because mothers prefer this technic since it supplies them with emotional gratification not obtainable through any other infant-feeding procedure. In this country the inclination to breast feeding is also again manifest, particularly in those areas where its proponents have strong faith in the psychologic benefits to be gained in setting up good mother-child relationships; foremost among these advocates are Powers of Yale; Aldrich and Spock at the Mayo Clinic; Montgomery of Wayne University in Detroit; McClendon of George Washington University, and some of the members of this Society, who as students of the beloved Dr. Joseph Brenneman are carrying on his philosophy of infant care.

Psychologic Considerations

Along with the prevailing inclination to breast feed babies, is the trend to feed them less coercively and less rigidly, to permit greater gratification through feeding them when they are hungry, as frequently as they want to eat, and in amounts and variety of food which will be determined by the infant. The terms "self-demand" and "self-selection" are being used more frequently, and the practice is being followed increasingly, more or less after the pattern set by Dr. Clara Davis' experiments at the Children's Memorial Hospital in Chicago. An appraisal of these methods and of the results of their usage in clinical practice would in itself supply

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

data not only for this paper but for a whole symposium. Instead, a description of the play of forces on this trend will be given here to illustrate the complexity of the drives involved in what was once called "simple" infant feeding.

Whenever a parent (or a physician or nurse in training, for that matter) is encouraged to feed a baby physiologically by offering the lactating breast or a carefully prepared and adequate substitute formula each time the infant is hungry, and without quantity-limiting or time-limiting as to duration of nursing, there appear sooner or later questions and doubts as to the efficacy and the necessity of such practices. In spite of a powerful biologic intuition in this regard, stronger cultural influences blot out and try to prevail over the instinctual. The mother asks, "But will I not spoil my baby by giving in to him this way and will I not become tied down to my child? What about my career?" The war veteran husband inquires, "Is this not poor discipline?" The business-man husband, successful in competition, queries, "Is this good preparation for later life? Will my child be able to survive the 'dog-eat-dog' practices of modern society?" The pediatrician ponders, "Is it good medicine to deviate from infant-feeding practices which have reduced infant mortality? Are we forsaking science for folk-medicine?" The nurse, tutored by the physician and ruled by the hospital, likewise fears to deviate from traditional feeding practices. Simultaneously with the development of a new trend comes conflict with prevailing methods. And so it is today in infant feeding, one unfortunate result being dilemma in the minds of parents of newborn babies. The pediatrician is also caught in a predicament and wonders how far he may go in applying the newer philosophy of feeding children. Infant-feeding practices of healthy babies now assume complexity, something heretofore seen only in treatment of unusual or sick children. On reflection it is clear that one reason for the intricacies of feeding is that it involves relationships of one person to another, eating being more than the ingestion of food for caloric needs in that it supplies emotional satisfaction of a basic kind as well. Its complexity is shown by the plethora of feeding problems of physically healthy children which demand so much time and patience in the everyday practice of medical practitioners and which, as Brenneman pointed out[8] many years ago, resulted from the inflexible applications of laboratory-proved feeding practices to live human beings each one of whom is individually different from every other one. It is hoped that the pediatrician will not sink hopelessly into his dilemma, following the policy of laissez faire or coasting along in traditional practices, but will instead attempt to treat his patients as individuals, making his own observations, testing and discarding, comparing notes with colleagues, and especially allaying the fears of parents who are caught in the pinch of conflicting practices.

It is clear that the trend of more breast feeding is part of a general tendency to consider the psychologic aspects of child care and child rearing. This approach is sponsored largely by persons within and outside of medicine who have had experience with psychiatry and who are influencing all branches of medicine as well as such fields as education, sociology, and even jurisprudence. It is part of the mental hygiene movement which began after the first World War and received new impetus from the recent war. This movement is a countertrend opposing a philosophy of child care which had its origin in several related but different sources, the Watsonian school of behavioristic psychology being one. Watson taught that children could be habit trained through conditioning and unconditioning much in the nature of the Pavlovian animal experiments on reflexes. This attitude, with its cold objectivity, appealed to the scientifically trained physician, since it stemmed from laboratory research and was more exact than other methods of child training which seemed haphazard, hit and miss, and based on sentiment. In recent years the philosophy of child care based largely on scientific research as applied indiscriminately to infant feeding has had new impetus. Research in nutrition has suggested the earlier use of certain foods as complements to the milk diet in order to provide minerals, vitamins, and protein in the endeavor to prevent illness due to deficiencies in these chemicals. For example, the feeding of liquid meat[1] as early as the sixth week of postnatal life is advocated to promote the formation of hemoglobin and red blood cells. Such research is often sponsored by commercial concerns who lose no time and spare no money in advertising the results, at times directly or indirectly creating the feeling in parents that this new method of feeding is necessary for the life and health of the baby, and further that if the physician in attendance has not advocated the usage of these foods he is to be viewed with scepticism, considered old-fashioned and unscientific, and a successor is to be sought amongst more "up-and-coming practitioners." Sorry to say, there are in our profession individuals who pride themselves on what they call "streamlined" child care, this being a speed-up plan of feeding which entails such practices as giving up the 2 a.m. feeding early in the neonatal period before the infant is ready for it, introducing solid foods by the sixth week, and arbitrarily placing the infant on a three meal a day schedule by 3 months, chronologic age being the guide post in each instance rather than physiologic need. Physicians and nurses advocating such technics are aided and abetted by a certain group of parents who fundamentally do not like infants because their care demands so much time, is costly, and is disruptive of parental routine and pleasure. These parents want their babies to be miniature adults and attempt to hasten their development through infancy. Scientific appraisal of human development shows that there is danger in interfering with natural growth processes; infancy

cannot be by-passed, curtailed, or interfered with. The host of feeding, sleeping, and learning problems which follow such endeavors bears testimony to this.

Significance of Protein

It is hoped that the impression is not given by what has been presented so far that science is at fault or that research in nutrition and infant feeding is to be discouraged because of evil intent. Rather, scientific study in all fields is to be encouraged, but with the hope that the results of each investigation will not be misapplied and that research in the humanities will be brought apace with that of science. At this point, mention should be made of the newer trend of feeding babies based on chemical and metabolic studies of protein nutrition. The significance of protein in health and disease is no more evident than in pediatrics. This foodstuff serves special function in the child by providing basic materials for the building of tissues during growth. It also acts as a therapeutic agent in certain diseases peculiar to infants and children. From the metabolic and chemical studies of Levine, Gordon, and others, it has been shown that premature infants require a high level of protein intake. This is because they have difficulty digesting and absorbing fat. It has been found that partially skimmed cow's milk mixtures in amounts designed to give approximately 120 calories per kilogram (55 calories per pound) of body weight and with protein in amount of 6 gm. per kilogram will produce larger gains in weight than will human milk, whole cow's milk, or evaporated cow's milk formulas. In contrast, healthy full-term babies are able to tolerate human milk well with its lower protein content of 2.2 gm. per kilogram and whole cow's milk of protein 2.5 to 4.8 gm. per kilogram in either evaporated or boiled form.

As the absolute rate of growth decelerates in later infancy, the protein may be reduced to daily levels of 3 to 4 gm. per kilogram. Protein intake below 2.2 gm. per kilogram in infants may lead to negative nitrogen balances, while levels above 4 gm. are wasteful, since there are no body depots for reserve protein and excess protein may tax the kidneys by the increased nitrogenous end-products. With further deceleration in the growth curve beyond infancy, lower levels of dietary protein per unit of body weight are required for nitrogen retention and protein deposition. Allowances fall from a maximum of 4 gm. per kilogram at 1 year of age to 1.4 gm. per kilogram for girls at 20 years. In cases of undernutrition, higher allowances are preferred at every age. Human or cow's milk ordinarily comprise the sole protein-containing food in early infancy. The protein content of human milk averages 1.25 per cent, that of cow's milk 3.5 per cent. A daily allowance of 2½ to 3 ounces per pound of human milk and of 1½ to 2 ounces per pound of cow's milk covers the protein needs of young full-term infants. Babies fed on a self-demand regime and receiving breast milk in larger satisfying amounts seem clinically to develop well, and their bodies appear to be able to judge correctly the amounts of protein needed. Those offered cow's milk formulas with a protein content of about 4.6 gm. per kilogram also do well clinically on a self-demand regime, although there have been no laboratory studies of either group of infants to determine defects of physiologic functioning of self-demand for human beings. When the infant is old enough to take additional foods, other proteins of animal origin (eggs, meat, cheese, fish) and some vegetable proteins (cereal, bread, potato, legumes) should progressively replace milk as the source of protein. In children above infancy, two-thirds to three-fourths of the total protein intake is preferably derived from animal sources, about 50 per cent of the total being supplied by milk.[2]

Feeding Mixtures Designed to Give 55 Calories per Pound

(From Gordon, H. H., and Levine, S. Z.: Feeding Premature Infants. Am. J. Dis. Child. 73: 442–452 (April) 1947.)

	Per Lb.	Gm./Kg.			% TOTAL CALORIES		
		Protein	Fat	Carbohydrate	Protein	Fat	Carbohydrate
Human milk	2½ oz.	2.2	6.7	12.9	7	50	43
Evaporated milk Carbohydrate Water to make	1 oz. 3 Gm. 2¼ oz.	4.8	5.5	12.9	16	41	43
Half-skimmed milk powder (Alacta) Carbohydrate Water to make	1 Tb. 5 Gm.* 2¼ oz.	6.0	2.2	19.4	20	16	64

*½ tablespoon Dextri-Maltose.

The role of proteins and their constituent amino acids is important also in such abnormal states as malnutrition, convalescence from acute illness, and the treatment of chronic disease. Children who have fever or are malnourished will have depleted protein storage, even beyond the normally lower level seen in childhood, because of an increased metabolism in this age period as compared to the adult levels. One of the commonly seen diseases of infancy is diarrhea, and protein constitutes one of the most important dietary elements in promoting recovery from this illness because it is much more easily

tolerated by the gastrointestinal tract than either fat or carbohydrates and because it assists in the formation of new tissue. The enteral feeding of properly heated milks, particularly protein milk, skimmed lactic acid milk, and skimmed milk with or without added casein has proved of great value in promoting convalescence from epidemic diarrhea of the newborn and infantile diarrhea of enteral or parenteral origin, as well as in such chronic diseases as pancreatic fibrosis, the celiac syndrome, and ulcerative colitis (nonallergic). Since evidence[3] is abundant to demonstrate that small amounts of unaltered protein normally absorbed into the blood stream are increased in digestive disturbances in early life, the usage of predigested proteins or enzymatic casein hydrolysates in their treatment is gradually replacing the practice of using native protein, thereby reducing the chances of subsequent hypersensitiveness.

The employment of native proteins by mouth, enzymatic casein hydrolysates enterally and parenterally, whole blood, plasma, and serum transfusions continues in the treatment of hypoproteinemia due to inadequate protein intake, excessive fecal loss or urinary excretion, skin seepage, plasmapheresis or hemorrhage, and defective protein production in the body. The group of illnesses with edema comprising such hypoproteinemic states includes malnutrition, infectious colitis, lipoid nephrosis, extensive body burns, shock, and cirrhosis of the liver. In the field of allergy, amino acid mixtures will probably serve an increasingly important therapeutic role because of the biologic nonspecificity of these substances as opposed to the action of such protein food as milk, egg, meat, fish, and wheat which permeate the gastrointestinal tract with great avidity and produce chemical symptoms of eczema, angioneurotic edema, mucous colitis, and bronchial asthma.

In concluding this paper, I must remark again on the important and difficult role of the physician whose work carries him into the full stream of change and trends, not only in infant feeding but in our society generally.

I am reminded in this regard of Bunyan's "Pilgrim's Progress," and find applicable to us in medicine the words of Mr. Honest to Contrite: "It happens to us, as it happeneth to wayfaring men;—sometimes our way is clean, sometimes foul, sometimes up-hill, sometimes down-hill; we are seldom at a certainty; the wind is not always on our backs, nor is every one a friend that we meet in the way."

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INTENSIVE COURSE IN PEDIATRICS REPEATED AT UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

The Intensive Course in Pediatrics presented at the University of Wisconsin Medical School in April 1947 is being repeated the week of February 23–27. Mornings, from 8 o'clock to 10:45, will be occupied with ward rounds and dry clinics. Lectures will begin at 11 o'clock.

The program is as follows:

Monday

11:00–12:00 Recent Advances in Control of Diabetes in Pregnancy and Childhood
Dr. E. S. Gordon

2:00– 5:00 Infant Feeding, Including That of the Premature Infant
Dr. J. E. Gonce, Jr.

Tuesday

11:00–12:00 Dermatologic Aspects of Pediatric Practice
Dr. S. A. Johnson

2:00– 5:00 Diseases of the Newborn, Including Hemolytic Anemia Due to Rh Incompatibility
Dr. K. B. McDonough

Wednesday

11:00–12:00 Tuberculosis in Childhood
Dr. H. K. Tenney

2:00– 5:00 Fluid and Electrolyte Balance in Health and Disease
Dr. P. P. Cohen

Thursday

11:00–12:00 B. A. L.
Dr. J. S. LePoidevin
Ethylene Disulfinate in Allergic States
Dr. Edward Zupanc

2:00– 5:00 Meningitis
Dr. H. K. Tenney

Friday

11:00–12:00 Technique of Intravenous and Bone Marrow Transfusion
Dr. J. R. Paul

2:00– 5:00 Respiratory Disease in Childhood
Dr. J. E. Gonce, Jr.

Notes on the Treatment of Chronic Hepatic Disease*

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A. M. SNELL

Doctor Snell, head of a section in the Division of Medicine at Mayo Clinic and professor of medicine at Mayo Foundation, Graduate School of the University of Minnesota, obtained his education in medicine at the University of Minnesota Medical School. He served in the Medical Corps of the United States Naval Reserve during both wars, and was commended by the Secretary of the Navy for meritorious service. He is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

IF A clinician of twenty-five or more years ago should visit a patient with cirrhosis of the liver in our hospital wards today, he would undoubtedly be much disturbed by the type of treatment being administered. He would almost certainly criticize the diet given as being entirely unsuitable for a debilitated patient, he would be critical of our rather casual handling of the patient's ascites, and he would be greatly puzzled by the use of such recently developed remedies as amino acids and concentrated human serum albumin. Within the relatively short space of a quarter century our whole concept of the nature of chronic hepatic disease has undergone so great a change that our hypothetic visitor would have great difficulty in orienting himself and in appreciating the significance of much that is done for the cirrhotic patient.

As many contemporary writers have pointed out, these revolutionary changes have developed over a period of years because of the application of advances gained by a long series of physiologic studies and from the information gained by the experimental production of hepatic disease. Treatment today is based on a number of well defined ideas which are quite adequately supported by available physiologic data. These ideas may be enumerated as follows: (1) Chronic hepatic disease is, in part at least, of nutritional origin. The nutritional defect may be solely responsible, or it may have rendered the liver unusually vulnerable to toxic agents and viruses. (2) Some of the most characteristic consequences of chronic hepatic insufficiency are due to a breakdown in protein metabolism, which is manifested in part by disturbances in nitrogen metabolism and by quantitative and qualitative changes in the plasma proteins. The nature of the metabolic defect is not as yet clear: It is suggested that the normal process of transmethylation is disturbed, possibly because of a specific deficiency in the intake of substances containing labile methyl groups. (3) The diseased liver is defective in the synthesis of proteins, in the manufacture of certain enzyme systems necessary to normal metabolism, and in its normal function of inactivating certain substances of hormonal origin. (4) Vitamin deficiencies may, and frequently do, develop in the course of chronic hepatic disease because of failure of synthesis or storage of these substances. Finally, it is believed that (5) many of the deficiencies just mentioned are reversible, and while one may not be able to restore the liver to an anatomically normal state, it may be possible for newly regenerated hepatic tissue to carry on all the essential metabolic functions of the organ.

To review the experimental and clinical evidence on which these ideas are based would greatly exceed the scope of this paper. The interested reader is referred to recent publications by Morrison,[1] Hoagland,[2] György,[3] and Weir.[4] In respect to the nutritional factor, one encounters reports of two general types of experiments: (1) acute deprivation of essential foodstuffs, which produces fatty change or necrosis and (2) long-term deficiencies, which are usually productive of changes more nearly simulating those seen in human cirrhosis. The preceding generalizations do not take species and other differences into account, but in general it is clear that in small animals maintained on diets deficient in protein, the vitamin B complex, choline, or methionine, diffuse hepatic injury of various types and degrees will develop. The process may be accelerated by adding fat and cystine to the diet, and it may be either relieved or retarded by yeast, choline, or methionine.

These experiments, it should be pointed out, do not necessarily apply to human beings whose requirements for protein, vitamins, specific amino acids, and lipotropic substances may be different from those of animals. However, in the sphere of human nutrition, some supporting evidence is available. In various sections of the world (Mysore, Hyderabad, North China, South Africa, and the West Indies) large groups of individuals subsist in abject poverty on inadequate diets, and as result of this long-term partial starvation there is an unusually high incidence of hepatic cirrhosis and other degenerative hepatic lesions. Such a situation has been observed, on a reduced scale, in the prisoners of World War II. In all of these groups of human subjects, alcohol and other chemical hepatotoxins can be eliminated as etiologic factors, but,

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under other circumstances, it is certain that such hepatotoxic substances are enhanced in their effect by previous nutritional injury to the hepatic cell.

Treatment of Cirrhosis

The Dietetic Program.—Diets used in cirrhosis have undergone many changes, the general trend being toward an extremely liberal diet with little or nothing restricted. Even the time-honored restriction of fat in acute epidemic jaundice has recently been shown to be quite unnecessary. The original cirrhosis diet advocated by Patek[5] (1937), which has been extensively modified and used by other workers in many clinics, contained 365 gm. of carbohydrate, 139 gm. of protein, and 175 gm. of fat. The diet in use at the Mayo Clinic prior to 1942, as reported by Fleming and me,[6] contained 500 gm. of carbohydrate, 110 gm. of protein, and 60 gm. of fat; it is now approximately the same as that advised by Patek.

Morrison[1, 7] and others have recently claimed special advantages for diets with much higher protein content (up to 200 gm.) and lower content of fat. The general experience of many institutions has led to a much more liberal use of both fat[8] and protein, which increases the palatability of the diet and makes it more easily adaptable for use in the patient's home. It is now agreed that the exact composition of the diet is of no great importance provided it contains 300 gm. or more of carbohydrate and 150 gm. or more of protein and supplies a total intake of 2,500 to 4,000 calories. The diet should be palatable and attractive, since many patients with cirrhosis have little taste for food.

Most clinicians find it necessary to make the diet of the cirrhotic patient fairly concentrated and to derive most of the protein and fat from milk, eggs, cream, cottage cheese, and baked and boiled meats. The milk may be fortified with powdered milk, powdered egg, and special proprietary preparations of high protein content. One preparation of hydrolyzed lower protein (ledinac) has been recommended by Lewis and his collaborators.[9] For patients unable to take solid food, special feeding formulas suitable for introduction by duodenal tube have been employed.

Perhaps the most important feature of any diet prescribed for the cirrhosis patient is that it must be eaten *in toto*. There is no special magic in any dietetic formula, and both Jack Spratt and his wife would presumably do equally well if they licked the platter clean. Witts, [10] in one of those fine sentences so often seen in articles from British sources, advised "the selection of those naturally occurring foods which can be most expeditiously used to increase the biological value of the diet."

Vitamin Supplements.—The diet in the original program for the treatment of cirrhosis laid down by Patek was heavily fortified with vitamins, a practice which not only persists but has been extended by other workers, notably Morrison.[1] The high cost of foodstuffs in these days, especially when a high protein diet is advisable, makes it necessary to consider the needs for special vitamin therapy in each case on an individual basis. Heavy dosage with vitamin supplements seems to be on the decline, brewers' yeast, cod liver oil, and citrous fruit juice being considered adequate additions by most workers. In those individuals showing specific symptoms of vitamin deficiency, specific treatment is necessary until the signs and symptoms of the particular syndrome disappear, when special treatment may be discontinued.

Liver Extract.—All the aforementioned programs for the treatment of cirrhosis have been supplemented by the parenteral injection of liver extract in various doses two or three times a week. The basis for liver therapy is not too well founded scientifically, and yet it seems to be of distinct clinical benefit. It appears to stem from the French school of opotherapy (about 1900), and has been revived at intervals by many investigators. The most recent stimulus has been provided by the work of the Rockefeller Institute group [2, 11] who have used large doses of a special preparation of liver extract intravenously. After a careful preliminary check for sensitivity, increasing doses may be administered until a total of 10 to 20 cc. is given daily two or three times a week; this is diluted to 50 cc. with physiologic saline or glucose solution. The most definite clinical effect observed is a considerable increase in appetite and in the patient's sense of well-being. Liver functional studies as reported by Labby and his associates[11] showed some rather unusual improvement from the laboratory standpoint. The Rockefeller Institute report seems, in short, to indicate clearly the clinical usefulness of liver extract given in this manner. The disappearance of ascites is noted in a high percentage of cases, and the period of survival is also lengthened, a matter to be mentioned later. Our own experience with liver extract given intravenously has been limited and somewhat disturbed by untoward reactions, but some encouraging results are already apparent and its extended use is contemplated.

Other Specific Substances.—The preceding paragraphs give the basis of the dietetic program and outline the extent to which it is usually supplemented. There are many who feel that such specific protective substances as methionine, choline, or choline plus cystine should also be added, and one must admit to some theoretic possibility of improving the program in this way. György[3] recommended the use of 2 gm. of methionine daily, as does also Morrison.[1] It is a fairly expensive preparation and is not always readily available; moreover, it is present in good concentration in a high protein diet. The use of methionine does not, incidentally, alter the course of epidemic hepatitis in any way, and there is no control study on record to prove the necessity of its use in the more chronic types of hepatic disease. Recently reported metabolism studies[12-14] raise a serious doubt as to its value in increasing nitrogen re-

tention under experimental conditions of either high or low protein intake.

Choline is less difficult to obtain and administer and, theoretically, may be used to advantage as a supplement in patients with an alcoholic background and a large and presumably fatty liver. The lecithin in the egg yolks contained in the diet, again, will probably supply all the choline that is needed under ordinary circumstances. In spite of the objections noted, it must be admitted that the addition of choline, choline plus cystine, or methionine in adequate quantity has produced some over-all improvement in clinical results (Beams,[15] Morrison,[1] Russakoff and Blumberg[16]). No well controlled data are available to give as a definite answer to the matter, and under the circumstances it appears justifiable to continue to use these specific agents in selected cases pending further developments in the field. Their use, however, is by no means essential and cannot be urged on anything except theoretic grounds.

Ascites.—The mechanisms by which ascites occurs in the cirrhotic patient have intrigued a generation of clinicians and physiologists. With the discovery of significant changes in the plasma proteins, notably a marked decrease in serum albumin, it was assumed that the problem was solved on the basis of simple hydrostatics. It was already known that portal venous pressures were greatly increased in such cases, and it seemed clear, theoretically, that a lowering of the serum albumin would reduce the osmotic pressure of serum to a point at which a free filtration of fluid from the portal vascular bed could occur. However, direct measurements of osmotic pressure did not entirely support this hypothesis. It was found that some patients with ascites had osmotic pressures of sufficient magnitude to counteract a very considerable increase in portal venous pressure, while others who were rid of their ascites had osmotic pressures below the critical level. This raised the question of a third factor; namely, some active interference with the normal output of urine. The work of Ralli and her associates[17] has contributed greatly to an explanation of this problem; they have demonstrated an antidiuretic factor in the urine of cirrhotic patients which diminishes or disappears as the patient improves and ascites clears. Presumably this antidiuretic factor originates in the hypophysis and under normal circumstances is inactivated by the healthy liver. If hepatic disease exists, the antidiuretic fraction is free to act, and in so doing it is capable of causing an active retention of fluid in the body. This concept of the mechanism of the formation of ascites is well supported by recent studies showing fluid retention in epidemic hepatitis;[18] this can be demonstrated long before the serum albumin is decreased and before portal hypertension develops.

In view of these observations, it seems clear that an active campaign to rid the body of accumulations of fluid accomplishes little until the hepatic cells begin to resume their normal function of inactivating this antidiuretic material. One cannot, at the present time, change the portal venous pressure, and elevation of the osmotic pressure of serum is almost equally unattainable. The moral is, of course, simple: do everything possible to restore the hepatic parenchyma, and the ascites will take care of itself.

In the past, ascites has received much more than its share of attention, often to the detriment of the patient. It is now believed that mercurial diuretics should be used sparingly and their use continued *only* if a satisfactory diuresis is obtained. Low sodium intakes, which might conceivably be helpful, are difficult to reconcile with a palatable diet and should not be pressed unless the patient can also maintain a good protein intake. Acid-producing salts should be used only if they do not cause digestive upsets. Tapping at intervals causes less hardship to the patient than any of the previously mentioned methods and may be continued for months or years without harm. The use of a button-like device which drains ascitic fluid into the subcutaneous tissues of the lower abdominal wall has been advocated by Crosby and Cooney.[19] It probably deserves a more extensive trial.

The really important considerations in the treatment of ascites are the achievement of a positive nitrogen balance and a restoration of the serum albumin to a near normal level; both depend upon some general improvement in hepatic function and are best achieved by the basic program outlined in earlier paragraphs. Some supplementary measures may, however, be required in cases in which the osmotic pressure of serum is greatly reduced and a negative nitrogen balance is present.

Salt-poor concentrated human albumin is an agent of great promise and, if available, may be given in divided amounts up to a total of 200 to 300 gm. Even larger amounts may be required to bring the serum albumin to a satisfactory level; thereafter, maintenance doses of 25 to 50 gm. given weekly may be used. Thorn and his associates[20] have provided detailed information in regard to the use of albumin in their recent series of reports. Its use in single or multiple 50 gm. doses produced striking increase in the volume of urine and a satisfactory rise in serum albumin in patients with cirrhosis. Considerable quantities of albumin, 80 per cent or more, were retained in the treated subject; there were only small losses in the urine, and an equilibrium was slowly attained between ascitic and plasma albumin levels. They recommend the use of albumin in severe cases of cirrhosis in which a positive nitrogen balance cannot be maintained and in which serum albumin cannot be increased on dietary therapy alone, as well as in long-continued hepatitis in which anorexia interferes with a normal dietary intake and a postive nitrogen balance cannot be attained. These encouraging reports should stimulate a further clinical use of albumin when it becomes more generally available, since it not only may favor the control of ascites but may also improve the general

nutrition of the patient and break into the vicious circle induced by the waterlogging of the intestinal coils.

Hepatic Coma.—This condition, the common terminal manifestation of advanced hepatic insufficiency, is more often than not beyond the reach of treatment when it is discovered. I have, however, personally observed a number of recoveries, and good results in the precomatose state are the rule rather than the exception. Coma is often precipitated by a hemorrhage, by tapping, by a standard dose of barbiturates, or by an intercurrent infection. It may develop with little warning, although hallucinations and psychotic behavior are frequent forerunners. There are two important factors to bear in mind in planning treatment: (1) these patients have a definite anoxia which is correctable, and (2) many show the neurologic features of the encephalopathic state encountered in deficiency diseases such as pellagra, which are believed to depend upon the breakdown of enzyme systems concerned with carbohydrate metabolism. These enzyme systems in turn contain portions of the vitamin B complex (thiamine, nicotinic acid). Treatment should include transfusion of freshly drawn blood (to provide new and normal hemoglobin), use of an oxygen tent, and the continuous infusion of glucose solutions containing at least 100 to 200 mg. of thiamine chloride and 250 mg. of nicotinic acid daily. Casein hydrolysates, at least a liter a day, will assist in maintaining nitrogen metabolism temporarily.

Hemorrhagic States.—These are most often due to prothrombin deficiency, which in turn is an indirect expression of severe and progressively increasing hepatic damage. Transfusion of blood is almost our sole reliance, unless the prothrombin time shows a positive response to the administration of vitamin K, which is only rarely the case. In the occasional case in which there is an associated thrombopenia, the condition is virtually hopeless. Curiously enough, patients may be tided over successive "waves" of prothrombin deficiency and eventually may make a satisfactory recovery.

Hemorrhage from Esophageal Varices.—This is a fairly common occurrence, especially in cirrhosis of long duration when portal hypertension has developed and the esophageal varices are of large size. The patient may be exsanguinated from the first hemorrhage, or he may survive many hemorrhages of lesser magnitude over a period of years. No entirely satisfactory method of treatment is as yet available. Splenectomy, omentopexy, and ligation of the coronary veins of the stomach, used singly or in combination, have all produced occasional satisfactory results, but failures are almost the rule. A direct attack on the esophageal vessels with the use of a sclerosing solution administered through the esophagoscope will be successful only if the varicose vessels do not extend into the cardiac end of the stomach. The procedure of injecting these vessels is difficult, tedious, and probably dangerous except in the hands of expert endoscopists.

The recent studies of Blakemore and Lord [21, 22] offer the greatest encouragement of those seeking relief from portal hypertension and recurring hemorrhages from esophageal varices. They have demonstrated portal pressures as high as 400 to 500 mm. of water (four to five times the normal) in patients with Banti's syndrome and portal cirrhosis. Since the venous pressure in the systemic circulation is low, it is possible to make an anastomosis with the hypertensive portal system with good prospects of permanence. Two procedures have been performed: (1) anastomosis between the severed splenic vein and the left renal vein, the spleen and left kidney being simultaneously removed, and (2) portacaval anastomosis in the manner of an Eck fistula. The good results reported appear to depend upon a newly developed technic for blood vessel anastomosis, using vitallium tubes and avoiding the use of sutures. In a series of cases reported by Blakemore and Lord,[22] recurring hemorrhages from esophageal vessels have been controlled, ascites has disappeared in some cases, and improvement in hepatic function has been reported. Their reports should be carefully studied, since the work represents a major advance in a most difficult field.

Results of Treatment

These are considerably beyond expectations if one considers the age groups involved and the advanced state of hepatic injury at the time treatment is usually begun. Just prior to World War II, Fleming and I[6] reported on 50 patients treated by the methods outlined earlier in this paper. Twenty patients were living after two years, and, of these, 11 were free of ascites; 5 others required only occasional tapping. Patek's most recently reported figures are even better, especially when considered in the light of his control series. Sixty-five per cent of his patients survived the first year as compared with 40 per cent of the controls; 50 per cent lived beyond the second year as compared to 20 per cent of the control group; and 30 per cent survived five years as against only 7 per cent of the controls. He described, as we have done also, repeated responses to treatment in the same patient, a most significant phenomenon. Morrison's[7] figures are equally impressive; of a group of 9 "compensated" cases of cirrhosis, all patients were living after a two year period; of 11 patients with ascites, all but 2 survived for two years. There was a corresponding decrease in the period of disability as compared to that of a control group.

The best results yet reported are those obtained by Labby and his co-workers[11] in connection with the intravenous use of liver extract. Seventy-seven per cent of the patients treated by them survived for two years; 57 per cent were free of ascites; and only a few were unimproved.

Many other workers have reported optimistically on their results. It should be noted that any series containing a large number of alcoholic addicts who have subsisted on inadequate diets will show a

higher percentage of good results than will an unselected group in which other causes of chronic hepatic injury may be encountered. Patients with cholangiectatic cirrhosis and those having residual infectious hepatitis are apparently much less likely to respond to any type of treatment.

Comment

Success in treatment of cirrhosis depends upon many factors: earlier diagnosis, attention to every detail of treatment, a diversification of the known adjuvants in therapy, patience, and persistence. Any agent which will increase the total metabolic efficiency of the damaged liver or will correct any part of the deficiency state produced by it should be employed. Since most patients with clinically demonstrable chronic hepatic disease are far advanced in the process of hepatic destruction when first seen, it is not likely that the patient will be overtreated. The alcoholic patient who cannot afford a single lapse from temperance may need expert psychiatric guidance. Minor infectious processes and trauma require special care, since they may be followed by a period of rapid decline. The most important single consideration is the maintenance of a normal caloric diet and an adequate intake of protein and vitamins by whatever means that may be feasible.

The importance of earlier diagnosis cannot be overemphasized. Until physicians generally are willing to risk a diagnosis of latent or compensated cirrhosis on the basis of a vascular "spider," a palpable liver or spleen, and bromsulfalein retention of 10 per cent in one hour, the best possible results will not be realized. The patient should be seen often and encouraged, especially in reference to his protein and total caloric intake. The patient who is not doing well may need brief periods of hospitalization, during which parenteral administration of glucose and amino acids may be instituted, the details of the diet are checked, and the status of hepatic function is reappraised. The first year after ascites makes its appearance is the critical period, and during this time every effort should be made to press treatment. Response to treatment may be slow; I have records of patients who showed little or no improvement for months yet finally achieved a very satisfactory state of health.

Far too many patients, probably 15 to 20 per cent, die of hemorrhage from esophageal varices even after substantial improvement in hepatic function has occurred and after they appear to be on the road to complete recovery. Once some stabilization of the disease process has occurred, the esophagus should be checked at intervals by roentgenologic and direct visual study, and the question of injection therapy or portacaval anastomosis should be considered. Only the first steps have as yet been taken in this field; it is conceivable that much may be accomplished in the future by these newly developed technics for the control of portal hypertension.

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The Management of the Allergic Child*

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H. J. LEE

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THE management of the allergic child presents one of the most challenging and interesting problems in clinical medicine. The syndromes provoked by allergic reactions often represent patterns of illness which may be present in various forms throughout the lifetime of the patient. Early recognition and adequate management can prevent, minimize the severity, or reduce the frequency of these reactions.

It has long been observed that the infant who suffers from infantile eczema is prone to have allergic manifestations of the respiratory tract develop in later childhood or early adult life. Likewise, the child with perennial rhinitis, pollenosis, or recurrent episodes of "asthmatic bronchitis" is a candidate for seasonal or perennial bronchial asthma.

The allergic background is often obvious in the explosive angioedema, rhinitis, or asthma which may be seen in an infant upon exposure to foods such as egg, nuts, fish, or seed products, or to inhalents such as animal danders or dusts. Repetition of the exposure or ingestion, with reproduction of the illness, may be sufficient to establish the causative factor.

The awareness of the offending allergen may not be as clear in cases of cyclic vomiting, pylorospasm, or recurrent colic. In these distressing problems a more complete study may be needed.

Infantile eczema is the most common manifestation of allergic disease seen during the first years of life. Lesions usually appear over the face and the flexural surfaces of the arms and legs, though greater areas of the skin may be involved. Eczema often appears while a child is on a restricted diet and while evironmental contacts are limited. Often lesions appear in potentially sensitive infants to whom multiple foods have been added at too early an age. It presents a problem in every case to the general practitioner or pediatrician, who is expected to cure or relieve it by changing formulae or eliminating recently added foods; to the dermatologist, who is expected to allay it by salves or light therapy; and certainly to the allergist, who is expected to make a few skin tests and present an immediate, definitive answer. We well know that it is in the rare case that the condition is relieved by one of these procedures. The usual case presents a far more disturbing problem.

Infantile eczema is usually the first manifestation of atopic sensitivity, which in other forms, chiefly rhinitis and asthma, may appear in later life. Allergic study requires a meticulous history of the appearance, the progression, the relapses, and the remissions of the dermatitis. Skin testing may be done by cutaneous and later intracutaneous technic. Occasionally, because of widespread dermatitis or dermographism, indirect testing by passive transfer is necessary. Serum from the patient is used to sensitize skin sites in a nonsensitive recipient. Intracutaneous tests of these sites are done and are controlled by simultaneous tests in nonsensitized areas. With this technic positive reactions occur only when specific circulating antibodies are present.

By either technic positive skin reactions may occur to substances to which there has been no recognized previous contact by ingestion or inhalation. Intrauterine sensitization, as described by Ratner, probably accounts for some of these reactions.

The importance of food as a factor in the production of infantile eczema is well established. Inhalent substances such as dusts and animal danders must be recognized as equally potent offenders. A program

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of management must consider all factors. Strict inhalent control is essential for successful management. The necessity for elimination of foods must be established by repeated observation.

Reduction or elimination of the commonly complicating infection is of particular importance. This may be impetiginous or a deeper dermal infection. The use of ointments to which the patient is not sensitive by contact, or of penicillin, may be of great help in controlling this complication. Continued observation by the physician who is constantly aware of the possible provoking factors can usually reduce the dermatitis to a level compatible with comfort. As this stage is reached, formerly eliminated foods important in the diet may be added serially to determine whether they may be taken without aggravation of the lesions.

The allergic reactions of the respiratory tract comprise the largest number of cases seen in preadult years. Perennial rhinitis, pollenosis, and asthma may appear at any age. Awareness that continually recurring respiratory symptoms may be of allergic origin helps materially in the early recognition. Recognition becomes easier in a family in which older children or parents suffer from allergic disease or in which a history of atopic dermatitis is present.

Usually the child has repeating episodes of what are thought to be "colds." These are manifested by nasal block, sneezing, and rhinorrhea and are often punctuated by paroxysmal cough, which may be croupy in character or may be associated with wheezing, commonly nocturnal. Episodes of so-called "asthmatic bronchitis" may occur. The above symptoms may be present with the physical findings of a pneumonic infiltration. In such cases an x-ray usually will reveal a patchy bronchopneumonia. Eosinophiles in the nasal secretion or sputum, or significant eosinophilia indicates an allergic mechanism. A further clue may be gained by the seasonal recurrence of these symptoms or by the regular reproduction after exposure to certain inhalents. The importance of pollen as a cause is well established. The realization that other environmental allergens, especially house dust, may cause these symptoms is more difficult but certainly is equally important.

These patients require a complete history and physical examination. Laboratory studies, including studies of blood, urine, cytology of secretions, and often sedimentation rate are considered preliminary to skin testing. This procedure should be sufficiently comprehensive to satisfy all the leads presented by the history. Skin testing should include environmental dusts, animal emanations, pollens, and molds of the geographic area, as well as representative foods. Incomplete studies may seriously limit the success of management.

The interpretation of skin tests and the possible errors therein need further discussion. As an example, a patient with a history of ragweed pollenosis presenting symptoms sharply limited to the period of ragweed pollenation may give skin reactions to many tree or grass pollens. Obviously these reactions are of no immediate importance in the evaluation or treatment of the ragweed pollenosis. They are of importance in demonstrating potential sensitivity, in that they may be the harbingers of future symptoms during the tree or grass seasons.

Reactions to food tests have been the source of many arguments as well as the cause of many failures in management. Faulty interpretation has certainly been a factor in depriving individuals unnecessarily of important foodstuffs for varying periods of time. Skin reactions to foods give important clues as to clinical sensitivity, but they are important only if they aid in pointing to foods which upon ingestion can be demonstrated to provoke or increase clinical symptoms. Except for those foods known to cause explosive reactions, any food elimination should be for a trial period. If, by trial eliminations, clinical comfort is established or the symptoms are reduced, the suspected relationship of a food can be further verified by the controlled additions of that food. Occasionally the presence of an increasing eosinophilia after a few days of ingestion of this food may be helpful in establishing a causal relationship.

Allergic reactions to foods commonly are quantitative. A slice of bread may be tolerated in a wheat-sensitive patient where more is not. Egg often may be tolerated in baked goods without provocation of symptoms. The allergic reaction to milk may be eliminated by the heat of condensation or evaporation. If milk is still not tolerated by these changes, soy bean substitutes may be given. The elimination of any food from the diet must be controlled by clinical observation. Often after a few weeks or months the gradual addition of the previously eliminated food in small or modified form may be attempted; this addition is usually tolerated, and then should be increased.

Active food allergy may exist in a patient with negative skin reactions. Here the detection of offending foods is aided by observation of a diet diary. When from this record, a food is suspected, purposeful ingestion of the food may be attempted to note an increase in symptoms or the maintenance of an increased eosinophilia.

The evaluation of reactions to inhalents may be more closely correlated with the history. This is particularly true of the many pollens, animal eminations, molds, and dust. In the presence of a definite seasonal history, suggesting pollenosis, cutaneous and intracutaneous test, the latter with serially increasing strengths of pollen extract, may produce negative reactions. Here study is not considered to be complete without the application of the dried pollen suspected to cause the difficulty to the conjunctival sac. Redness, swelling, itching, photophobia, and nasal block may ensue, demonstrating the mucosal sensitivity. These ophthalmic tests should never be done until cutaneous and intracutaneous tests to the pollen are proved to be negative.

A severe constitutional reaction may otherwise be the result.

Treatment is established after allergic study is completed. A program of management is based upon a review of the history and the results of laboratory study and skin tests.

The evaluation of food study has been discussed. Inhalent offenders, such as animal danders, are best controlled by complete avoidance. This may mean the loss of the family pet, which may keep a youngster in a simmering status of poor control. The exposure to dust and feathers may be reduced by the use of plastic, or dust-proof casings on the pillows and mattress. Dust in the bedroom, where the patient spends a third of his life, should be minimized as completely as possible. Practically, however, dust must be considered as ever present a problem as pollen, and specifically treated by hyposensitization.

It would be ideal if disturbing pollen factors could be completely eliminated or if the pollen-sensitive patient might be sent to an area consistently free from his offenders. Practically, this is not possible, and he must be treated so that neutralizing antibody to the pollen will develop. Adequate development of this blocking antibody will minimize symptoms to an increasing degree. Treatment with pollen extract as well as the extracts of mold spores and dust is accomplished by giving increasing doses of the extract at intervals until adequate levels are attained.

Treatment should be initiated as soon as symptoms occur. Uncontrolled allergic reactions appear to favor the development of further sensitization. Food sensitivities observed in infancy or early childhood may disappear by avoidance or by partial or quantitative elimination. Inhalent allergens which cannot be eliminated usually continue to cause symptoms, and further breaks in tolerance upon subsequent exposure are the rule.

Specific treatment may be preseasonal, where related pollen sensitivities exist, or perennial, where many groups plus mold and dust must be given. The length of treatment is dependent entirely upon the response of the patient. This response may be subjective, but also may be guided by a reduction in skin reactions to standardized extracts.

Concurrent with specific treatment, relief of symptoms is necessary. The use of epinephrine, theophyllin, and ephedrine in the control of asthmatic paroxysms is well established. For continued medication, theophyllin in cocoa butter used as a rectal suppository is usually more effective than the epinephrine suspensions in oil. The latter, because of an overdose of the active ingredient or reactions to the oil, may increase rather than decrease symptoms. Iodides or ammonium chloride to reduce the tenacity of the sputum, or ipecac to provoke emesis and the accompanying discharge of mucous plugs, are important adjuvants.

The continuing search for antihistaminic drugs for the relief of allergic reactions has produced two preparations which are potent. Both benadryl and pyribenzamine have rapidly established a place in the symptomatic treatment of allergic rhinitis and pollenosis, as well as urticaria. The results in asthma and atopic dermatitis have not been as encouraging. Side reactions, particularly drowsiness and gastrointestinal disturbances, may accompany the use of either or both. These drugs are to be used for the symptomatic control of the varied conditions. The basic antigen-antibody reaction is in no way affected by their use as it is by hyposensitization. This is illustrated by patients seen by all of you during the recent pollen seasons in whom bronchial asthma has developed while continuing these drugs for the relief of pollenosis. The use of the drugs in a patient with a high level of tolerance attained from hyposensitization permits greater pollen exposure, particularly during seasonal peaks, than would otherwise be compatible with comfort.

A word must be said about the use of penicillin in the treatment of asthma. It is effective in the elimination of secondary infection due to penicillin-sensitive organisms. One must be aware that penicillin is a sensitizing substance and that unless specific indications are present its use may increase rather than decrease the problem.

A brief review of factors in the management of the allergic syndromes seen in children has been presented. Where this control is satisfactory, it may minimize the morbidity associated with these processes and may prevent them from becoming problems in adult life.

WISCONSIN STATE BOARD OF EXAMINERS

The next meeting and examination of the Wisconsin State Board of Examiners in the Basic Sciences will be held on April 3 in the Assembly Chamber, State Capitol, Madison. The last filing date is March 27.

The following meeting and examination will be held on June 5 at the Plankinton House, Milwaukee. The last filing date is May 29.

Fracture Disabilities

By MERRITT L. JONES, M. D.
Wausau

M. L. JONES

A graduate of Harvard Medical School, Doctor Jones served his internship and a residency at the Peter Bent Brigham Hospital in Boston. During World War I he was chief of orthopedic service at General Hospital No. 1 in New York. At present he is chief of staff of Wausau Memorial Hospital and a preceptor for the University of Wisconsin Medical School. The doctor is a fellow in the American College of Surgeons and a member of the American Board of Surgery.

THE old adage, "Necessity is the mother of invention," certainly is apropos to the impetus that war gives to science. In the global war, medical science played an all-important part, and through it much new and valuable information as to the care of the injured has been obtained.

The management and treatment of fractures have especially been emphasized. While treatment by fixation and rest had previously been accepted, the increasing number of fractures brought new and altered methods of treatment, so that the pendulum began to swing in the opposite direction,—to that of fixation and motion. This has been accomplished through various types of reduction apparatus, skeletal fixation apparatus with metal supports, and various other methods combining the principles of internal and external fixation without the necessity of open operation or external immobilization. Just how far these newer concepts will replace the older and tried methods remains to be seen. Certainly they should not be used by those who are not well trained in surgery.

Henderson has made the statement that the care of a fracture may be divided into five stages: (1) diagnosis, (2) reduction, (3) rentention, (4) immobilization, and (5) function. While all of these are essential, and dependent one upon the other, the restoration of function is by far the most important from the standpoint of the patient. All too often one is asked to look at x-ray pictures of a fracture before and after reduction in which the reduction is excellent and the union is good, only to be dismayed when, on seeing the patient, a marked concomitant loss of function in the given part has taken place. It is felt that many of these prolonged and permanent disabilities can be avoided. In other words, some of the more commonly observed disabilities are those of treatment rather than injury. While it is true that the general practitioner, just as in the past, will be called upon to take care of the majority of fractures, he must recognize his own limitations and in the more difficult cases seek early and adequate consultation.

In treating fractures one must be constantly alert to the fact that the injury is never limited to the bone alone and that it also involves the soft tissues and frequently the neighboring joints. Subsequent swelling, hemorrhage, and the results of disuse immobilization frequently are as important, if not more important, than the fracture itself. It is because of this soft tissue injury, as well as the fact that reduction is usually easier before swelling and muscle spasm have taken place, that the early reduction of fractures is advocated by those familiar with handling such cases. Early accurate reduction is essential, since through it further trauma, as well as bleeding and swelling, is often avoided. The method by which this can be accomplished is influenced by many factors and varies considerably with each case as well as with the particular physician in charge. In general, one might say, "Use that method which in your hands has proved to be the most efficient and attended by the best result." The best way to prevent a bad result is to anticipate it, and the best way to judge any method of handling fractures is by the end result, and particularly that which concerns function.

The preservation of physiologic function must be supervised throughout the healing period, and should not begin with the removal of the fixation dressing. It should be started as soon as reduction and fixation have been accomplished. The remaining joints of the extremity should be carefully watched over, and both active and passive motion started so as to maintain a full range of motion. As an example, in a fracture of the wrist, immobilized in plaster from the base of the fingers to the elbow, the cast should be cut away in such a manner as to allow free motion of the thumb and fingers, especially at the proximal joints. The patient should be instructed to move and use the fingers as much as possible and, if necessary, passively put the joints through their full range of motion several times a day. In the meantime, the arm should frequently be put through a full range of motion at the shoulder. If the patient is in bed, placing the hand behind the head for limited periods of time during the day is of assistance. If necessary, passive motion should also be carried out through the help of the nurses and attendants. Codman's pendulum exercises are often of considerable service. In the leg, the same principles are indicated. A hallux rigidus is a very disabling condition. Voluntary contraction of the quadriceps, as well as passive stretching through manipulation of the patella, will frequently obviate

a contracture of the quadriceps tendon. The meticulous attention to such details is often far more important than many other problems stressed in the literature.

Most physicians agree that with the removal of fixation dressings follow-up physiotherapy is all-important and should be stressed and continued until the maximum amount of function has been restored. Useful work is also of assistance in many cases. The restoration of function at this time frequently represents a critical phase in the patient's convalescence, since too early or too late action may undo what otherwise would have been an excellent result. In addition, one must be constantly prepared for those conditions associated with delayed union, nonunion, and certain types of bone atrophy.

In the average case, following adequate reduction, some type of fixation must be maintained. If plaster is the method of choice, the next essential is the manner of application and the position of the various parts. As a general rule, the extremity should be sufficiently padded, especially about the various joints and bony prominences. The plaster casing should be thick and firm enough to hold the part in the desired position. The immobilized joints should be placed in the so-called positions of election unless for some reason this is contraindicated. These positions, briefly, are as follows:

(1) The thumb in the position of apposition.
(2) The fingers in the grasping position.
(3) The physiologic curves in the back.
(4) In the shoulder, 45 degrees of abduction and forward flexion, and a neutral position insofar as rotation is concerned.
(5) The elbow at 90 degrees flexion in the desk worker and at 120 degrees in the laborer. If both elbows are involved, one should be placed in each position.
(6) The wrist in 15 to 25 degrees of dorsiflexion.
(7) The hip in 20 degrees of flexion, 5 to 10 degrees of abduction, and in the neutral position insofar as rotation is concerned, or in 5 degrees of external rotation.
(8) The knee, 15 to 20 degrees of flexion.
(9) The ankle, 5 to 10 degrees of dorsiflexion, or at least with the foot at a right angle to the leg, and preferably in the neutral position.

Characteristic deformities and disabilities are prone to follow certain types of fractures and injuries. In the care of patients with such injuries, these should be constantly kept in mind.

Fractures in the digits should be reduced as accurately as possible. Active motion, together with physiotherapy, should be instituted at the earliest possible date. It is important to see that the dressings interfere as little as possible with the remaining fingers and that the patient puts these fingers through a full range of motion actively or, if necessary, passively many times a day.

Fractures of the metacarpals which are allowed to heal in deformity frequently are accompanied by marked impairment of function. On rare occasions an open reduction is necessary to insure a good result.

Since the hand has two main functions, namely, that of prehension and grasping, the importance of the thumb, which forms one of the arms of the human pliers, cannot be over-emphasized. The loss of the thumb or interference with its activity often constitutes a marked disability. The stove, boxer's, or Bennett's fractures of the base of the first metacarpal may be particularly troublesome. These may be treated after reduction by immobilization in plaster with the thumb in full abduction, or by some type of traction. Rarely the fragment of bone may have to be removed.

Fractures of the carpals, particularly fractures of the carpal scaphoid, may prove to be very difficult. Such fractures are frequently missed, since the line of fracture may be quite indistinct. Here we have a bone without periosteum, and union must depend upon endosteal callus. Nonunion is, therefore, the most frequent complication. As a rule, immobilization should be carried out with the hand in radial abduction and, if necessary, over a prolonged period of time until the x-ray pictures demonstrate that union has occurred. In cases with nonunion, various methods such as drilling and grafting have been used. Frequently, in spite of nonunion, the patient may have very little, if any, pain and a good useful wrist. On other occasions the nonviable fragment, preferably the entire bone, should be removed.

In **fractures about the wrist** involving the radius and ulna (so-called Colles' fracture), the most important point to remember is that the articular surface of the radius normally faces downward and forward. This anatomic position must be maintained if one is to expect a good end result. To accomplish this it is often necessary to immobilize the hand in palmar flexion and ulnar deviation. If the hand has been in the Cotton–Loder position, the plaster should be removed in approximately ten to fourteen days, and the hand and wrist elevated to the neutral position or, preferably, in dorsiflexion.

Fractures of both bones of the forearm often try the skill of even those especially adept in fracture management. Most of these fractures occur in the lower half of the bone. Shortening, together with rotation and overlapping, is almost the rule. One common error is not to be satisfied with what would give a good functional result and, in the endeavor to get perfect apposition, to carry out repeated attempts at reduction, with additional trauma and often further displacement. If the fracture of the radius is above the insertion of the pronator terres, immobilization should be carried out with the forearm in full supination. If it is below the pronator terres, the forearm should be placed in the mid-position. Early full motion in the remaining joints of the arm should be carefully supervised. It should

be remembered that in this particular location latent displacement through muscle pull is not at all rare, and this should be controlled by repeated x-ray examination.

Fractures about the elbow, including those of the proximal end of the radius and ulna as well as those about the distal end of the humerus, require considerable judgment. Here various types of surgery are often indicated. Nature is very kind to individuals with such injuries, and, in spite of severe trauma, a useful degree of motion frequently remains. Children, as a rule, regain function in this joint with only moderate assistance from the physiotherapist. In adults, however, the problem is not as easy. Forced manipulation and forced passive stretching of an elbow joint under anesthesia are rarely indicated.

Fractures of the shaft of the humerus have as an added complication the musculospiral nerve and nonunion. The most frequent residual deformity is an anterior bowing, and this should be carefully guarded against. Various methods of reduction and fixation are carried out. Open reduction may have to be resorted to. The value of the hanging cast method of treating fractures of the shaft of the humerus seems to have been demonstrated. If this method is used distraction of the fragments is the most common error, so that frequent x-rays are indicated.

Fractures about the shoulder joints, especially in patients over 40 years of age, often lead to marked impairment of function unless very carefully handled. Orthopedists and industrial surgeons are all too familiar with those changes which soon take place in the shoulder, resulting in various degrees of what is termed "frozen shoulder." The period of immobilization should be shortened as much as possible, and unnecessary immobilization vigorously condemned. Codman's pendulum exercises, together with physiotherapy, are indicated at the earliest possible date.

Disabilities following fracture of the clavicle are frequently due to prolonged immobilization and various types of treatment rather than to the fracture itself. Here union nearly always takes place and the functional result is satisfactory, even with malposition. In the rare case of nonunion, this is the one place in the skeleton where an intermedullary graft is of service.

Fractures of the pelvis are mentioned to emphasize again that they are usually multiple and that many of them can be improved by traction. We have all been taught to investigate injuries to the urethra in such patients. I wonder, however, how many physicians recognize the concomitant damage to the sacroiliac joints which often accompanies such fractures, and institute appropriate treatment.

The most trying fracture in the region of the hip is the one involving the neck of the femur. This is because of the disturbed circulation and the incidence of nonunion. During the last few years we have learned that some type of metal fixation is the method of choice in these cases. In my own cases, I prefer an open reduction using the Cubbin's incision, followed by fixation of the fragments with a Smith–Peterson nail. Intertrochanteric fractures of the femur nearly always unite and usually can be reduced by traction. The most common complication is a coxa vara due to too early weight bearing. When the fragments are badly displaced, an open reduction and fixation with one of the various types of nail plates may be necessary.

Fractures of the femur are particularly difficult because of the familiar contracture of the quadriceps. This may be guarded against by using various types of traction, which allow a given amount of motion in the knee, or, if plaster is used, placing the leg at the knee in 20 to 25 degrees of flexion. Active, as well as passive movements of the patella are imperative.

Fractures of the patella require accurate apposition. Here again we have a bone without periosteum and must depend upon endosteal fixation. Physiotherapy should be started as early as possible. Fractures about the knee as well as interarticular fractures elsewhere require more accurate apposition than do most fractures. A joint surface with incongruity usually leads to a permanent disability.

In the leg, fractures of the lower end of the tibia are important because of nonunion. Here accurate alignment is necessary, and an open reduction may have to be carried out, particularly if the fracture line is spiral. This type of fracture is usually produced by forced rotation and is accompanied by a high fracture of the fibula. The latter is conducive to injuries to the branches of the external popliteal nerve. A fracture of the anterior lip of the distal end of the tibia often requires open reduction and pinning. In trimalleolar fractures it should be remembered that the astragalus always travels with the fibula.

In caring for a so-called **Pott's fracture**, three common errors in treatment should be recognized and avoided, namely, (1) failure to close the ankle mortise, (2) lack of dorsiflexion due to shortening of the heel cord, and (3) distortion due to too early weight bearing. The use of a walking iron during immobilization is highly recommended.

One of the most disabling fractures in the foot is that of the os calcis. Many methods of reduction have been advocated. Whatever method is used, restoration of the salient angles is mandatory.

I would again like to stress the importance of physiotherapy, not only as a necessary adjuvant to the follow-up treatment of fractures, but one which should be instituted and supervised throughout the convalescense of the patient. The ability of any physician undertaking the treatment of fractures and the success of the various types of treatment are best judged by the end results. Function, to my mind, is paramount. Function plus accurate reduction and union is the result one tries to obtain.

Present Status of Pulmonary Resection for Carcinoma and Inflammatory Diseases of the Lung*

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J. W. GALE

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A. R. CURRERI

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A DISCUSSION of pulmonary resection and its application in the treatment of four major thoracic diseases in twenty minutes precludes the mention of many important details.

The term pulmonary resection, including lobectomy and pneumonectomy, implies radical surgery. Fifteen years ago we would have been reticent to enter into such a discussion. (One of us [J.W.G.] performed a lobectomy in 1928). Our experience was limited, the surgical technic poorly developed, the complications numerous, and the mortality high, and the end results left much to be desired. Since then a better understanding of the problem, the development of a satisfactory technic coupled with more efficient diagnostic procedures, and better preoperative and postoperative care have contributed to a higher percentage of good results and a mortality no higher than that following many major abdominal procedures. The patients mentioned will include only those seen and operated upon by us during the past two years. The number and mortality will be given. A detailed analysis will appear in a separate article.

Early ambulation is practiced except in the tuberculous group. Patients are out of bed on the second or third postoperative day. Most of them are ready to leave the hospital by the tenth postoperative day, but are held longer because they frequently have to travel to distant points throughout the state.

Carcinoma

Carcinoma of the lung accounts for about 10 per cent of all malignancies. It is most frequently seen after 40 years of age. Men are afflicted about five times as frequently as women. Eighty per cent of the lesions will be found in the larger bronchi near the hilum, and the disease is apparently on the increase. Constant irritation and trauma to the respiratory tract are thought by some to be of etiologic importance. The onset, like malignancy in other organs, is insidious, but before it has progressed far certain signs and symptoms will offer definite clues pointing to some alteration in the physiology of the respiratory tract. These, in order of their importance, are (1) Cough. This will be present in over 70 per cent of the cases. Many patients already have a chronic cough, particularly cigarette smokers, but the important point is the change in character. It may suddenly become nocturnal or productive and perhaps persist throughout the day. (2) Hemoptysis. In about 60 per cent of the cases it may appear very early with slight streaking or as a sudden copious flow of bright red frothy blood. (3) Pain. This occurs in one half of the cases and is usually described as being deep-seated and dull in character. Patients will not infrequently localize the site of the lesion when describing the location of the pain. Too often cough and hemoptysis are attributed to tuberculosis, and the patient may be sent to a sanatorium for treatment without further examination or study. It must be remembered that tuberculosis or bronchiectasis existing singly or together does not preclude the possibility of a new growth. (4) Weight loss may occur early and continue. It is frequently due to worry, blood loss, anorexia, or a constant irritative cough. Late in the disease the patients become cachectic due to widespread metastases, and still later fever, night sweats, pneumonitis, atelectasis, and dyspnea appear. If the primary lesion has invaded contiguous organs or distant structures, a variety of symptoms and signs become evident.

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Involvement of neighboring structures occurs when the primary tumor is no longer confined to the lung, such as hoarseness due to involvement of the recurrent laryngeal nerve, dysphagia with esophageal invasion, venous congestion of the head and neck following obstruction of the superior vena cava, and Horner's syndrome with involvement of the sympathetic nerves. With distant metastases the signs and symptoms are dependent upon the organs involved.

A relatively small tumor may succeed in blocking a bronchus, with resultant atelectasis of the lung area supplied by the involved bronchus. If the block persists, infection supervenes, resulting in pneumonitis followed later by lung abscess or bronchiectasis. Any patient over 40 years of age reporting frequent bouts of pneumonitis should be viewed with suspicion.

It is most unfortunate, but it is the exception rather than the rule for us to see these patients in the early stage of the disease when definitive treatment would result in an arrest of the process. Diagnosis is much easier in the early cases, before the carcinoma masquerades as one of the serious complications. Twenty-five years ago it was not so important to make a diagnosis of pulmonary carcinoma because there was no satisfactory treatment available. Much progress has been made in thoracic surgery, especially in the last decade, and good definitive treatment can now be instituted.

Diagnosis

What can we do to arrive at an earlier diagnosis in these cases? Probably two factors are most important. First, through propaganda to the public, we can keep them cancer-conscious. This, however, will help very little unless we as physicians understand how to proceed at arriving at a satisfactory diagnosis. A careful history will be of inestimable value, but a physical examination of the chest may reveal little or nothing in the early stages. Other tests, however, in order of their usefulness can be added. 1. Roentgenograms of the chest should be made. Exposures in the anteroposterior position and, if necessary, lateral and oblique views should be taken. Good films interpreted by a competent roentgenologist are probably the most useful diagnostic procedure. 2. Bronchoscopy is important. Since many carcinomata occur in the bronchi near the hilum, they can be visualized, location noted, and a biopsy taken. No growth will be seen in about 50 per cent of the cases, but other valuable information in the form of fixation, distortion, and purulent drainage will be obtained. 3. Sputum and bronchial secretions can be collected, and utilization of special stains may show malignant cells. This procedure has not enjoyed great popularity, but recent developments have made it one of the most valuable of any laboratory procedure. 4. Exploratory thoracotomy should be reserved for those patients in whom all tests have failed to permit correct diagnosis or in those whose diagnosis is equivocal. The operation is simple and relatively free of danger in the hands of a thoracic surgeon. The small risk is insignificant when compared to advising the patient to wait and see what happens. Carcinoma of the lung like all other malignancies is progressive and metastasizes. To procrastinate is to doom the patient to sure death.

Treatment

Once the diagnosis is made there is only one satisfactory treatment: complete removal of the lung on the involved side along with the mediastinal lymph nodes. The operation is not difficult in experienced hands. The lung lends itself to removal. The patients following operation are not deformed respiratory cripples but soon return to their position in society.

During the past two years we have operated upon 26 patients with carcinoma of the lung. Resection has been possible in only 50 per cent of the cases because of widespread metastases throughout the mediastinum. There were two deaths, one following exploration and a second three weeks after operation—a mortality of 8 per cent.

Bronchiectasis

Bronchiectasis was first described by Laennec more than one hundred and twenty–five years ago. It is usually associated with infection which causes destruction of the involved bronchial walls with infiltration of the surrounding peribronchial tissues. The involved lung area becomes dark blue in color, fibrotic, and atelectatic. The bronchial mucous membrane is replaced by granulation tissue which is bathed in a putrid, foul-smelling, mucopurulent secretion giving rise to from a few cubic centimeters to over a liter of sputum daily.

It is not within the scope of this paper to review the literature bearing on the etiologic factors brought into play in the development of this condition or the various theories regarding the types of the disease and its prevention. We are aware that its inception frequently occurs in early life. Such diseases as measles, pertussis, and influenza often appear as possible etiologic agents. Aspiration of foreign bodies and tonsillectomy under general anesthesia are much less important as causative agents.

Symptoms

Bronchiectasis as we have encountered it at the State of Wisconsin General Hospital during the past twenty years has been of a chronic nature. Regardless of whether it occurs in the child or in the adult, it is characterized by frequent acute exacerbations of fever, cough, putrid breath, hemoptysis, and the expectoration of a foul-smelling sputum. Chills and drenching night sweats are not infrequent during the acute attacks. Each of these bouts represents an accompanying pneumonitis.

The signs and symptoms of the disease are so typical that the diagnosis can be made quite easily.

The diagnosis alone, however, is not sufficient. It is most important to determine accurately the location and extent of the disease. Ordinarily the lower lobes are the common sites, but the upper lobes also show varying degrees of involvement. In many of these cases the condition is erroneously diagnosed as tuberculosis, chiefly because of the accompanying hemoptysis, which, incidentally, is more common in bronchiectasis. Complications may also present bold signs and symptoms. Infected congenital cystic disease, carcinoma, lung abscess, and bronchial stenosis may present similar symptoms. In long-standing cases amyloid disease and pulmonary osteoarthropathy are usually present. Brain abscess or empyema may cause the patient to seek the physician for attention. A systematic and careful examination is necessary to rule out these complications and to permit one to arrive at a correct diagnosis. Roentgenograms in several views, lipiodol filling of all the lobes, and bronchoscopy are all necessary adjuncts to the physical findings. About 35 per cent of the cases will show bilateral involvement. Bacteriologic studies and investigation of the paranasal sinuses should not be neglected. The latter have been shown when infected to be important as an etiologic agent producing suppurative disease of the respiratory tract.

Treatment

The treatment of bronchiectasis is divided into two types: conservative and surgical. The different conservative measures employed are too numerous to mention and are for the most part grossly ineffective. All patients enjoy remissions in spite of these measures. It is admitted that spontaneous cures do occur in the early stages of the disease. Probably the most valuable nonsurgical treatment is postural drainage. This frequently fails because it is improperly carried out. The head and chest must be lowered far below the level of the lumbar region, permitting the patient to evacuate the copious noxious secretions from the bronchial tree. It must be repeated several times per day and the position maintained for a sufficient length of time to empty the bronchi completely.

In the chronic well developed conditions the disease is progressive, disabling, and many times revolting because of the putrid odor of the breath and secretions. Society rejects the patients and their families avoid them. Obviously we are confronted with a definite pathologic process which unless eliminated will progress and shorten the life of the patient. Surgical procedure such as artificial pneumothorax, oleothorax, plombage, and thoracoplasty are mentioned only to be condemned. Phrenicotomy may cause improvement, but the operation of choice is lobectomy. This may include the removal of one or more lobes at one stage. Not infrequently the lingula of a left upper lobe or right middle lobe is involved along with the lower lobe. In such instances it is possible to remove only the involved portion of a lobe through the technic of segmental resection. If the disease is bilateral, it is customary to attack the side with the greater involvement first, and this may result in such complete improvement that further surgery is unnecessary. Three of the five lobes have been successfully removed. Preoperatively, postural drainage is instituted with extreme vigor, accompanied by aerosol penicillin and/or streptomycin after the sensitivity of the organisms is determined. Every effort is made to render the patient as good an operative risk as possible. The degree of amyloidosis is determined. During the past two years we have performed lobectomy on 33 patients at the State of Wisconsin General Hospital, with three deaths, a mortality rate of 9 per cent. One patient returned for reoperation and removal of a segment of upper lobe which was still causing symptoms. No cases were closed without completing the operation or determined inoperable because of adhesions or associated pleural infection.

Abscess and Gangrene

Abscess and gangrene of the lung can very well be considered as the same clinical entity. Earlier writers drew a sharp line of distinction between the two conditions, chiefly on a basis of the acuteness of the infection and the rapidity of tissue destruction. It is quite obvious that either may exist separately or the two conditions may appear simultaneously. Most authors now consider them both as destructive processes which under certain conditions fail to localize early or before the fulminating process has produced death.

It is difficult to estimate the frequency of lung abscess, because undoubtedly many occur in which the patient is not sufficiently ill to seek medical attention. These abscesses heal spontaneously and in most instances go unrecognized.

The condition occurs in individuals regardless of age and sex. Foreign body aspiration, pneumonia, and surgical operations around the mouth and teeth are important etiologic factors. Blocking of a bronchus by a new growth is also conducive to abscess formation. Organisms most commonly found are the streptococcus, pneumococcus, staphylococcus, and the spirochete and fusiform bacillus. Fungus infection must also be considered. Most abscesses are located in the lower lobes, lying at the root of the lung or at the periphery.

During the acute stage of the disease there is a general systemic reaction associated with fever, chest pain, sweating, loss of weight and strength, anorexia, and toxemia. The white blood cell count is high. Later, sputum appears in various quantities which is apt to be followed by subsidence of the severe reaction.

The hyperacute and gangrenous conditions are fulminating in nature, progressing so rapidly that the patient is moribund or dead in a very short time.

If the patient survives the acute stage of his infection, two courses may ensue, namely, a spontaneous cure or the persistence of a chronic infection.

Time does not permit a discussion of the treatment of the acute stage except to say that in certain instances surgical drainage is indicated and in other instances is mandatory.

The chronic abscess is the type most frequently seen in a large general hospital. They present the same signs and symptoms as those in the acute stage, but milder in nature. Toxemia, however, persists with intermittent exacerbations dependent upon the efficiency of the drainage. In the older chronic cases the cavity becomes surrounded by a thick fibrous tissue wall, atelectatic parenchyma, and an indolent epithelial lining constantly bathed in putrid infected secretions and associated with pulmonary osteoarthropathy and amyloidosis. Small and sometimes fatal pulmonary hemorrhage occurs not infrequently.

The diagnosis of the condition is not particularly difficult, since the signs and symptoms point definitely to a suppurative process. Roentgenograms taken at the proper angles will demonstrate the abscess and its location. Bronchoscopy will assist in ruling out foreign body or new growth. Bronchography seldom adds to the diagnosis except that it may demonstrate the degree of parenchymal involvement.

Treatment

The treatment of chronic lung abscess for many years consisted of different types of surgical drainage. The abscess which was deep-seated necessitated the destruction of varying amounts of relatively normal lung parenchyma. Many rigid-walled cavities failed to collapse after drainage; bronchial fistulae persisted; fatal hemorrhages were not infrequent. Most radical plastic procedures were often necessary; and several years later, when the patient appeared cured, the abscess would recur.

During the past seven years we have felt that lobectomy is the proper method of treatment in the chronic cases because (1) it insures complete ablation of the diseased process; (2) it eliminates the possibility of complications such as air emboli, brain abscess, hemorrhage, secondary plastic operations, and recurrence; (3) it has not been uncommon in our experience, particularly with peripheral abscesses beyond the vision of the bronchoscope, to find that a new growth or foreign body also exists and that the abscess is a complication of rather than the cause of the pulmonary disease; (4) the lung parenchyma and bronchi surrounding the abscess are eliminated as a source of continued suppuration and toxemia; and (5) the mortality is lower.

The preoperative and postoperative care is the same as that used in the treatment of bronchiectasis. During the past two years we have had 10 cases of lung abscess. Lobectomy has been performed in ten instances, with a mortality of 10 per cent. Of these cases, 1 revealed new growth, 2 foreign body, and all showed the rest of the affected lobe involved in bronchiectasis, smaller abscess, etc., rendering the lobe useless.

Tuberculosis

An omnibus discussion of pulmonary resection would be incomplete without a few remarks concerning its use in pulmonary tuberculosis. During the past five years an increasing number of papers have been presented dealing with rather large groups of patients upon whom lobectomy or pneumonectomy had been performed. Even now the indications for such procedures are not clearly defined. We are doing an increasing number of these operations. Although we are not radical in our approach, many cases are referred to us from the various sanatoria for major surgery; therefore, we naturally receive more upon whom it is felt this procedure is indicated.

Some feel that the removal of a tuberculous lobe or lung will eliminate the disease entirely. Obviously, these individuals have failed to understand the fundamental pathology of the disease. It will, however, when indicated, not infrequently throw the balance in favor of the patient and permit his natural resistance to overcome and arrest the remaining infection.

Indications

Briefly, our indications for resection at the present time are (1) bronchial stenosis with complicating atelectasis, frequent bouts of pneumonitis, bronchiectasis, or chronic suppuration; (2) lesions which thoracoplasty will not control, such as tuberculoma, basilar cavity, and certain tension cavities; (3) chronic cavitation in which there is a questionable diagnosis of tuberculosis; (4) cases of tuberculous bronchitis in which thoracoplasty has failed to convert the sputum, provided there is sufficient normal bronchus to permit satisfactory operative amputation and closure; and (5) cases in which thoracoplasty has failed to close large cavities, control hemorrhage and existing bronchiectasis.

All the above indications, of course, are based on the premise that the opposite lung offers no contraindication to the procedure.

We are convinced that thoracoplasty is the operation of choice in all cases in which careful study shows it has a greater chance of success than failure. Resection can always be employed at a later date and in many instances to a greater advantage because of the improvement obtained through thoracoplasty.

During the past two years we have performed resection in 34 cases of pulmonary tuberculosis, with the conversion of sputum in 80 per cent and with a mortality of 0 per cent. Sufficient time has not elapsed to permit an estimate of what the final results will show, but most of the operations have been performed in otherwise hopeless cases and on patients upon whom many other procedures have been tried. We feel the procedure is justified if our percentage of good results drops much lower than those quoted.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Penicillin Reactions

Apparently penicillin is directly irritating when injected intrathecally, and it may also cause venous irritation and thrombosis when continuously injected intravenously. However, all local reactions, including the painful one upon intramuscular injection, are seen much less frequently when crystalline penicillin G is employed.

The skin reactions resulting from the systemic administration of penicillin include urticaria, either generalized or localized, morbilliform rashes, vesicular eruptions, ecchymosis, purpuric eruptions, and eruptions typical of toxic erythema multiforme or of erythema nodosum. There has been a number of reports of the aggravation of pre-existing skin diseases of wide variety, and it seems that penicillin not infrequently aggravates fungus infections and that fungus infections may cause increased reactivity to penicillin. There is good evidence that reactions do not follow the administration of the Romansky formula any more frequently than they do the administration of penicillin in aqueous solution or by other routes. That the sensitization is due to the penicillin itself and not to the peanut oil or the beeswax is indicated by the fact that in patients who have been sensitized by the administration of the Romansky formula, the urticarial or other reaction will develop when penicillin is again given in aqueous solution. Considerable studies on beeswax itself to determine whether any pollen extracts have been carried over into it have yielded negative findings.

Joint involvement and reactions simulating serum sickness have been reported, as have also gastrointestinal disturbances. Barksdale (1946) said that at the Naval Hospital at Bethesda, Maryland, several cases of neuritis due to penicillin have been seen and that complaints of pain in the peroneal nerve have been frequent. Five cases of complete foot drop were observed, 2 of them requiring five months to clear up.

Many patients object to the taste and smell of aerosolized amorphous penicillin and find it irritant to the tongue or oropharynx; complaints often are minimized by a change to other lots of the drug. In a few patients black and sore tongue or stomatitis develops. Segal and Ryder (1947) recorded edema of the lips or the mucosa of the mouth. When crystalline penicillin G, which is virtually free of all impurities and tissue irritants, is used in aerosol therapy it apparently does not cause any blackening of the teeth, the gums, or the tongue and probably does not cause as much upper respiratory tract irritation as the amorphous salts.

Christie and Wyatt (1946) very interestingly pointed out that the introduction of the new chemotherapeutic agents, the sulfonamides and more particularly penicillin, has brought into existence a most significant and previously unknown condition, namely, that the sudden killing or attenuating of the infecting organisms leaves the tissues of the body to dispose of the resulting debris to an extent not before known. They said that this altered reaction to injury of the body tissue by infection often roentgenologically simulates neoplasm and may be easily confused with syphilis and other conditions, thus posing a considerable problem for the roentgenologist.

However, certainly by far the most frequently occurring reaction to penicillin given parenterally is urticaria. These urticarias occurring in association with penicillin therapy are very bizarre; they may occur at the beginning, several days after the institution, or several days—perhaps even as long as a month—after the termination of therapy.

Pillsbury *et al.* (1947), on the basis of a considerable experience with urticarial and other allergic reactions to penicillin, recommended a scheme of management of such reactions as follows: (*a*) Stop the administration of penicillin immediately, except possibly in occasional instances in which there is a critical need on the part of the patient for the drug. (*b*) Administer benadryl or pyribenzamine in a dosage of 50 to 100 mg. three times daily by mouth to adult patients, and expect that the effectiveness or lack of same will ordinarily become apparent within twelve hours, though it may be necessary in some instances to administer the antihistamine compound as often as every four hours round the clock. (*c*) If the reaction to penicillin is severe or if it is considered necessary to continue its administration without interruption despite the reaction, benadryl may be given intravenously in a dosage of 5 to 10 mg. slowly in 20 cc. of physiologic saline solution. The hypnotic effect of this intravenous administration is said to be very startling, and Pillsbury *et al.* were not convinced that it does not possibly have some dangerous potentialities (*d*) Upon the subsidence of the urticaria and accompanying symptoms, a test dose of 1,000 units of another manufacturer's penicillin may be administered intramuscularly, provided that facilities for the administration of epinephrine or of benadryl intravenously are at hand; it is recommended that the administration of an antihistamine drug by mouth be continued during this period. (*e*) If no reaction to the test dose occurs within six hours another dose of 10,000 to 20,000 units may be given, and if this

(Continued on page 259)

. . . . THE PRESIDENT'S PAGE . . . .

Current Business

THE midyear meeting of the A.M.A. was held in January in Cleveland. Two meetings a year were decided upon by the House of Delegates during the San Francisco meeting in July 1945. The first supplemental meeting was held in Chicago last year and consisited of morning and afternoon sessions of the House of Delegates over a two day period, nothing more. During the annual meeting in Atlantic City last June, the House decided that the supplemental meeting should consist of two days of scientific program planned especially for the general practitioner as well as meetings of the delegates from the State Societies. This plan was followed for the Cleveland meeting.

The reports are that the scientific program and exhibits were unusually good but that the attendance was small, too small, in fact, to justify the amount of effort and inconvenience caused those who contributed to them. The word "report" is used because the delegates do not have an opportunity to attend any of the scientific features of the meetings. The continuation of the scientific program and possibly the necessity of a supplemental meeting of the delegates were not discussed at this meeting, but it seems likely that it may be a subject for discussion at the annual meeting in Chicago this year.

The delegates' report of the meeting in Cleveland will be received in all probability with this issue of the *Journal.* You will be aware from this and previous reports that different aspects of the same subject recur to engage the attention of the delegates. This is evidence of the significance of these subjects to the general subject of medical care and medical practice, and they involve matters in which several groups are concerned. Some phase of medical education is one of these subjects. In Cleveland it recurred in a resolution on the allotment of interns to hospitals approved by the A.M.A. Council on Medical Education and Hospitals. This Council has approved 734 hospitals for intern training with facilities for 8,000 interns. Since there are only 6,000 students graduated each year, it is obvious that all of the available places cannot be filled. Because the students express a preference for places in certain hospitals, usually those in teaching centers many of the approved hospitals are unable to fill their quotas, or in some instances find it difficult to secure interns. This has resulted in the feeling that a more equitable distribution of interns might be devised, probably on the basis of bed capacity.

The resolution which was approved by the delegates calls for a committee of five to be appointed by the speaker, two of whom are to be chosen from practitioners of general medicine, to study the methods of allocating interns.

While the Council on Medical Education and Hospitals is primarily concerned with and solely responsible for the approval of hospitals for the function of training interns, they do not and, because of the nature of the selections, can not determine their allocation. The American Hospital Association, the American Association of Medical Colleges, and the students are also concerned with this choice. Neither of the organizations determines the hospital to which a student will be sent for his internship. This is a choice of the student, and as long as he is operating in a field of scarcity he has a free choice from a large group of hospitals.

It is difficult to see how this Committee can add to the efforts already being made by the Council on Medical Education. The Council has already provided for a joint consideration of this subject with representatives from the American Hospital Association and from the Association of American Medical Colleges. Under any circumstance, in the last analysis, the student, if he is allowed the freedom to choose as he now is, will make the decision.

It is enlightening to talk to students on this subject. Medical schools do have lists of preferred internships, but the student does not, however, necessarily accept these as the best ones. Among students there has long been a system for evaluating the desirability of the various approved hospitals for intern training. They gather their own information from questionnaires which they send each year to alumni of their own schools.

The Council on Medical Education and Hospitals of the A.M.A. can approve hospitals for intern training; it cannot allocate interns.

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« « « EDITORIAL » » »

Introducing the Guest Editorialist

EVER since he earned the privilege of adding M. D. to his name, Thomas Parran has served the health of the nation and the world through the United States Public Health Service. Doctor Parran began as a rural sanitation worker in 1916, gained recognition on public health research and administrative assignments in 14 states, and in 1936 received the appointment to Surgeon General.

His twelve years as Surgeon General have been accompanied by tremendous strides in public health advancement. Public health and the private practice of medicine have worked more closely than ever in the interests of the nation's health. Around the world these activities have left their mark on the health practices of many nations.

In 1935, Doctor Parran acted as chairman of the United States delegation to the Ninth International Conference on Dermatology and Syphilology in Budapest. Three years later he was chairman of the delegation to the Tenth Pan-American Sanitary Conference in Bogota, Colombia. In 1941 he studied civilian health conditions in Great Britain and aided in the purchase and shipment of food to that country under Lend-Lease. In 1946 he was chairman of the conference to establish the World Health Organization and is now a United States representative on its Interim Commission.

The Spotlight on Research

THE National Advisory Health Council, composed of distinguished physicians and scientists, recently declared, "There are few purposes for which public funds could be more appropriately used than to discover ways to prevent and cure illness and to prolong the useful years of life."

Congress has concurred in this opinion by allocating almost 40 million dollars to the U. S. Public Health Service for research for the fiscal year 1948. This appropriation not only enables us to intensify our work at the National Institute of Health and its affiliate, the National Cancer Institute, but also permits the expansion of research grant-in-aid to universities, hospitals, and other research institutions throughout the country.

Proposed projects of these nonfederal research institutions are submitted to the Public Health Service and are referred for approval to one of the three national advisory councils composed of eminent scientists in various fields of medicine and related disciplines. The University of Wisconsin's Edwin B. Fred is a member of one of these groups, the National Advisory Health Council. The other two councils deal with cancer and mental health respectively.

Once a research project is approved and funds made available, the scientist is given complete freedom in his work and he is encouraged to publish reports of his findings without federal approval or clearance. His principal responsibility to the Public Health Service is to provide an annual review of progress. We do insist, however, that funds advanced shall be used for *additional* research and not as a substitute for funds which could be obtained from other sources. Also, we continually stimulate outside donors and foundations not only to continue but to increase their contributions to scientific research.

In addition to intensive research in cancer, our present explorations are concerned with a better understanding of antibiotics; research into the cardiovascular diseases; the virus and rickettsial diseases; the use of streptomycin in tuberculosis therapy; and other challenging fields.

The need for even greater expansion of federally financed research is apparent to most scientists, and there seems to be general agreement that there should be adequate machinery for the coordination of this work, including a National Science Foundation. This was recommended by the President's Scientific Research Board last fall.

We have been fortunate in having in Congress men who understand the scientist's problems. Two Wisconsin men have been particularly outstanding in their support of health measures: Representative Frank B. Keefe, as chairman of the Labor-Federal Security Subcommittee of the House Appropriations Committee, has done much to further cancer and other research projects; and former Senator Robert M. LaFollette, Jr., who in 1938 was co-sponsor of the nation's first venereal disease appropriations bill. It was subsequent to LaFollette's legislation that Dr. John F. Mahoney of the Public Health Service developed the penicillin rapid treatment therapy which has so greatly advanced the control of venereal disease.

With continued professional cooperation, public interest and Congressional support, the future of medical research in America looms brighter now than it ever has before.

Thomas Parran, M. D.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

M. S. NICHOLS

Our guest writer, Doctor Nichols, has been a member of the staff of the State Laboratory of Hygiene for many years. He is primarily a chemist, but his varied interests and experiences have made him an authority in several of the divisions of the field of clinical pathology.

Laboratory Diagnosis of Pin Worm Infections

IT IS seldom possible to find either the pin worm (Enterobius vermicularis) or the ova in feces specimens. This is because the female pin worm naturally migrates to the perianal region to deposit her eggs. The gravid pin worm is also said to "explode" at times and scatter the eggs rather widely outside the intestinal tract in this location. Based on this habit of the pin worm, Dr. F. H. Van Hope, East Orange, New Jersey, in the *Journal of the American Medical Association*, vol. 125, p. 27, 1940, describes an improved method of laboratory diagnosis of pin worm infections. The method is as follows:

1. Secure a piece of transparent scotch tape about ⅜ to ½ inch wide by 2½ inches long.

2. Place the scotch tape over the end of a small test tube with the adhesive side distal to the rounded end of the tube, and hold the ends in place against the tube with the thumb and index finger.

3. Place the end of the tube so covered against the anal opening and rock the tube to and fro so that the sticky side of the tape makes firm contact with the surfaces and folds in this region.

4. The sticky side of the tape picks up the eggs.

5. The tube holding the tape is then applied to the center of an ordinary 1 by 3 microscope slide, and the two ends are then spread out so that the tape makes a smooth even contact with the slide and is held there by the adhesive.

6. Do not allow the tape to extend over the ends of the slide as the other surface must be flat on the microscope stage.

7. The material containing the ova, if present, will be found in the central part of the slide covered up with the scotch tape with the smooth side of the tape exposed.

8. Since the tape is transparent, search for the ova can be made directly through the scotch tape with the low power of the microscope.

The number of ova found will be variable. Sometimes only one or two ova will be found on a slide, while in some cases the scotch tape will show hundreds of ova.

Pin worm infections in North America are rather common in children. Surveys have shown the incidence to be about 40 per cent in the general population and somewhat higher in institutions. Adults in some communities may have the infection to the extent of 20 per cent.

Photograph of a scotch tape preparation showing numerous pin worm ova.

Infection occurs in various ways, but according to Chandler they are most probably air borne or conveyed by the hands after scratching the itching region around the anus. Shaking of sheets from a contaminated bed scatters the eggs into the air from which they may be taken into the nasal or oval cavity and be swallowed. It is well to remember that the ova require contact with the air before they become embryonated.

While the life of the pin worm is comparatively short, only a few weeks, reinfection makes eradication of the worms a tedious process especially in a family in which there are a number of children.

—M. STARR NICHOLS, Ph.D., *State Laboratory of Hygiene.*

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

P. A. BREHM

Doctor Brehm, a native of Sutton, Nebraska, graduated from the University of Nebraska College of Medicine, Omaha, in 1925. Following internship at Columbia Hospital, Milwaukee, and residence at Johnston Emergency Hospital of that city, he spent ten years in private practice there. For the past ten years he has headed the Industrial Hygiene Division of the State Board of Health.

The Progress of Industrial Health Services

After World War II, there was some doubt whether the interest in industrial health programs would continue under a peace-time production basis as it had during the manpower conservation emergencies of the war. Those who had watched the growth of industrial health services before and during the war were convinced that this interest would not diminish greatly, if at all. The progress of industrial health since V–J Day has shown that this opinion was justified.

Much was learned during the war regarding proper engineering and medical control of occupational diseases. This interest and knowledge is being extended more and more today, particularly with respect to the toxicology of the new materials and processes used for the first time as necessary steps in war production. Sanitary working conditions and facilities are as important now as during the war.

A good example of the increase in one health service during our peace-time years is the growth of industrial nursing. The number of nurses decreased somewhat after the end of hostilities due mainly to a reduction in our labor force. The only plants to discontinue this program entirely were those few industries shutting down completely. In over two years, there has been an increase in the number of nurses employed and an actual net increase of over twenty-five plants that have never had this coverage.

Not only are industries continuing with a physical examination program, but in many instances they are making the examinations more comprehensive and are adding other special diagnostic procedures. The number of industries adopting an examination program has increased. We can expect a greater coverage of this health service as the result of a growing interest on the part of the medical profession to understand the health problems of industry and to stand ready to help.

More and more of our medical colleges are offering industrial medical courses to undergraduates. A few of the medical schools have developed some good postgraduate instruction courses. Because of the rapid advance of industrial health, there is need for more training in industrial medical subjects. The industrial health problems confronting the practicing physicians are increasing; they should learn more about occupational diseases, the toxicology of industrial exposures, and the physical fitness of the worker in relation to his job. Industrial medicine has progressed beyond the treatment of injuries—it is a recognized specialty. If we want qualified industrial physicians we must devote more effort to training them.

The most striking examples of fostering a better understanding between industry and medicine were the in-plant visitation type of clinics held in three Wisconsin cities during April 1947. The clinics were exceptionally well attended, and many of the physicians saw manufacturing processes and hazards for the first time. This was the first venture of its kind in Wisconsin; mistakes were made, but much was learned which should make future clinics of that kind more successful.

The activities and interest of the Industrial Health Committee of the State Medical Society should accomplish much to acquaint the practicing physicians with the needs and problems of industry. More of the plant-visit type of clinics are needed year after year in every section of the state. These clinics, on a smaller, county society level and devoted exclusively to a full discussion of the hazards and control measures seen during the plant tour, will develop and maintain a greater interest and appreciation on the part of the medical profession. One major project has been to compile comprehensive and detailed recommendations for standing orders to guide the industrial nurse in handling the various cases of industrial and non-industrial illnesses and accidents. There has been a real need for such guidance—particularly by those nurses who must render such care without the direct medical supervision of a part-time or full-time plant medical director. The resultant improvement in relations and service will be apparent.

The advance of industrial health requires an appreciation of the problems plus the unity of action —that is happening now.—PAUL A. BREHM, M. D., *Supervisor, Industrial Hygiene Unit.*

Important New Cancer Form Provided

ARTHUR VAN DUSER, M. D.
State Board of Health

RECENTLY all doctors and hospitals were sent a new cancer case record and report. This message is intended to consider briefly the reasons therefor.

The importance of cancer as a cause of death, economic burden, community loss, and family suffering scarcely needs reiterating; however, let us remind ourselves that in 1 out of every 5 persons cancer develops during their life and 1 out of every 8 deaths is caused by cancer. Restated differently in units of time, in United States cancer strikes 1 person every two minutes and condemns to death 1 person every three minutes.

Roughly, 50 per cent of the patients with cancer can be saved from death by the proper and full application of the present knowledge of this disease; 25 per cent of the total patients with cancer are now being cured for five year or larger periods; and an additional 25 per cent could be cured under favorable conditions of early diagnosis and early and adequate treatment according to nationally known and recognized physicians—general practitioners and specialists. In number of additional lives saved, this represents better than 1,500 yearly for Wisconsin.

This thought is expressed with the due recognition that it is easy to speak of early diagnosis and treatment but that much effort and diagnostic skill particularly on the part of the general practitioner are entailed to accomplish this. However, indications are that the medical profession recognizes and welcomes the task. Until such time as the ultimate goal of the discovery of the specific cause or causes of cancer and better methods of therapy arrives, it appears timely and wise to get the immediate cancer goal of reversing the preventable portion of deaths to lives saved. In considering how to achieve this goal most quickly it is accepted that lay persons, physicians and cancer and health agencies are in the need of assistance of varying nature and degrees. This may be financial, follow-up of patients, medical consultation, postgraduate clinics, more or better treatment facilities or diagnostic aids, lay education, coordination of cancer efforts, or any of multiple other needs. Therefore, one reason for the devising and sending out of the new form is to get information on these factors which influence the obtainment of early diagnosis, early and adequate treatment.

In addition, the form provides information for a statistical study of basic cancer morbidity and mortality information in Wisconsin, such as cancer by age, sex, site of lesion, kind of lesion, amounts and kinds of treatment given, possible etiologic factors, and the correlation of survivals as well as deaths with this information. It is obvious that if the form is properly executed the information accumulated will be of considerable value in the future plans and efforts of the medical profession to reduce cancer morbidity and mortality.

Members of the cancer committee of the State Medical Society, the Wisconsin Cancer Society, and the State Board of Health have corroborated in devising the form. It is intended to be used not only as a report form, but also as a cancer case history in the doctors' offices, if they so desire, as a hospital cancer case record for its registry and as a history record for all patients, cases and suspects seen in cancer clinics.

The reported information comprising a state cancer registry will by follow-up of patient be kept reasonably current. The State Board of Health will tabulate this material and make it available on a state, local and institutional basis. The accurate completion of the form on cases seen by the doctor is a definite additional contribution by him in the fight against excessive cancer deaths. There are an estimated twelve to sixteen thousand cancer cases and about 3,000 physicians in Wisconsin. This means the completion of about one cancer form every three or four months per physician.

SEE PRECEDING PAGE!

CANCER: RECORD FOR DIAGNOSED OR SUSPECTED CASES

Also: Official Report Form

Approved by: American College of Surgeons; Committee on Cancer, State Medical Society of Wisconsin; Wisconsin State Board of Health.

If cancer is diagnosed keep WHITE copy in hospital or MD's cancer files. Send CANARY copy to Cancer Division, State Board of Health, Madison 2, Wis. (Reportable, Wis. Statutes, Section 140.05)

Hospital _____ Case Number _____

County and City _____ Date _____

Patient's Name _____ Address _____ Phone _____

Responsible Relative _____ Address _____

Occupations in Past 10 Years (Nature of duties) _____

_____

Previous Illness, Operation, or Accident _____

_____

Family History (Especially Cancer—Whom and What Organ) _____

_____

Age	Sex	Date Birth	SMWD	No. Child.	Descent	Nativity	Yrs. in U.S.	Years in Wis.

HISTORY:

Dates (Mo. and Yr.)

Initial symptoms . . . . . _____

Medical advice sought . . _____

First diagnosis . . . . . _____

Dates (Mo. and Yr.)

First treatment . . . . . _____

First cancer operation . . _____

Recurrence . . . . . _____

SYMPTOMS: (circle or underline) Cough, hemoptysis, pleuritic pain, expectoration (type and amount), difficulty in swallowing, early satiety, loss of weight, tarry stool, hematemesis, increasing constipation or diarrhea, blood in urine, vaginal discharge (watery, purulent, bloody), breast lumps or pain, fatigability, weakness, body ulcers or masses.

GENERAL APPEARANCE

T.P. _____ Pulse _____ Weight _____

EXAMINATION OF SKIN, HEAD, THROAT, AND NECK—

BREASTS—

(OVER)

CHEST and ABDOMEN—

USE ADDITIONAL SPACE FOR POSITIVE FINDINGS

PELVIS—

GENITO-URINARY SYSTEM (Including Prostate)—

RECTAL—

Describe Cancer Appearance, and Size in cm.

OTHER SYSTEMS—(Or Pertinent Laboratory Data)

MICROSCOPIC EXAMINATION OF TUMOR (By Whom and Where)

FINAL DIAGNOSIS (Including Hodgkins Disease and Leukemia)—

Clinical ---------- Primary Site ----------

Microscopic ---------- Metastasis to ----------

TREATMENT GIVEN—(Extent of Operation—Dose of Radiation and Filter, If Known; Other Therapy)

IMMEDIATE RESULT—(Death or Postoperative Discharge)	LATE RESULT—(Alive or Dead)	
	1 year ----------	4 year ----------
	2 year ----------	5 year ----------
	3 year ----------	6 year ----------

INSERT X-RAY FINDINGS UNDER PROPER REGION—ALSO BRONCHOSCOPY, GASTROSCOPY, PROCTOSCOPY, ETC.

Signature of Examining Physician

Address

The
MEDICAL FORUM

The Wisconsin Medical Journal — February, 1948

CO-OPS START ACTION TO GET HEALTH CENTERS

VA No Longer Honors Streptomycin Requests

Prescriptions for streptomycin are no longer being acknowledged for payment by the Veterans Administration in its home-town program for veterans care, the VA chief medical officer, Dr. H. W. Baxley, Milwaukee regional office, recently notified Thomas J. Doran, director of Wisconsin Veterans Medical Service agency.

The VA officer said that the Wisconsin State Pharmaceutical society has been given a similar notice. He stated that it is the present policy of the VA to limit the administration of streptomycin to cases suffering from some type of tuberculosis and only those cases which are in hospitals.

Each case will be reviewed by the VA branch office before the use of streptomycin is authorized, and when such authorization is given, the streptomycin will be supplied through the Veterans Administration.

Magnuson Replaces Hawley as VA Medical Director

Dr. Paul B. Magnuson, nationally-known orthopedic surgeon and closely identified with the reorganization of medical care in Veterans Administration hospitals, was named chief medical director for the VA by Carl R. Gray, Jr., administrator.

He succeeds Dr. Paul R. Hawley, who resigned Jan. 1 as medical chief and who is now serving Mr. Gray as special assistant and advisor on medical problems.

Dr. Magnuson will continue to work closely with Dr. Hawley in assuring that there will be no change or delay in the VA medical program due to these changes in personnel. Dr. Magnuson, a native of St. Paul, has been with the VA since Jan. 1945.

Farmers Union and Labor Groups Arouse Interest Through Organizational Meetings

Balsam Lake—The Farmers Union of Polk–Burnett county became the first cooperative in Wisconsin to take definite action on the so-called co-op health bill passed at the last session of the legislature when it formed the Polk–Burnett Cooperative Health association at a meeting here on January 27.

A seven-man directorate was authorized at the meeting to organize and incorporate the new cooperative and to draw up the chapter and by-laws. According to a release in the *Balsam Lake Ledger* of Jan. 29, the duties of the cooperative will be to "co-ordinate, initiate and assist in the organization of cooperative health plans, institutions and hospitals and to carry on correlated activities."

Plan 10-Bed Hospital

The co-op hospital law under which the association was organized was the first of its kind in the nation. Worked out jointly by the state medical society and the cooperatives, the act permits cooperative associations to form and operate nonprofit, prepaid sickness and hospital plans and to construct and operate nonprofit hospitals.

The action is the culmination of meetings held recently at Milltown and Balsam Lake under the direction of John J. Leipzig, Group Health Mutual insurance company, St. Paul. Mr. Leipzig was active in working for the co-op enabling act as legislative representative for the Wisconsin Association of Cooperatives.

At the meeting Mr. Leipzig outlined the merits of establishing a prepayment medical plan and cooperative hospital and advocated a minimum of 1,000 family memberships in the hospital service plan in order to support a 10-bed hospital. Mr. Leipzig did not stress any particular location in Polk or Burnett counties for the establishment of the hospital, although several persons at the meeting called attention to conditions in their communities.

The *Ledger* reported, "Because Osceola has already been approved by a federal survey for government aid in constructing a hospital, some of the sponsors of the plan favored constructing the hospital there. Representatives from Milltown indicated they were ready to exert every effort to have the hospital located in their village. Site of the proposed hospital has not definitely been determined, say the backers of the plan."

"An initial sketch of the plan would indicate the sponsors intend to sell shares in the hospital at $100 each and to sell membership in the prepayment medical and hospital service at a price somewhere between $50 and $105. While nonmembers would be admitted to the hospital whenever there are facilities to care for them, yet they will pay the same fee rate as charged by other hospitals."

It is reported also, that discussions are under way in the Superior and Kenosha areas in regard to formation of cooperative health associations in those communities. Labor groups as well as farm organizations have evidenced interest in these plans.

ON THE INSIDE

Subject	Page
Blue Cross–Blue Shield	6
Capitol Views	3
Chiropractors	2
Industrial Nurses Meet	5
Medical Examiners	7
Midwest Conference	2
Nursing Situation	7
Public Law 113	2
Rural Health Conference	3
VA Commends Doctors	8
Wisconsin Physicians Service	4
Wisconsin Plan	5
Wisconsin Press Comments	6

Public Law 113 Helps Physicians Restore Their Disabled Patients to Full, Self-Supporting Life

How many times have you had to tell a physically disabled patient to cut his hours of work or get a new job more suited to his capacity for work? If you were an employer, would you pay that patient enough to earn his own living despite illness or disability—enough to maintain his self-esteem, his family responsibility and his status in the community?

Thanks to Public Law 113 a service designed to return disabled men and women to remunerative employment is within reach of your telephone.

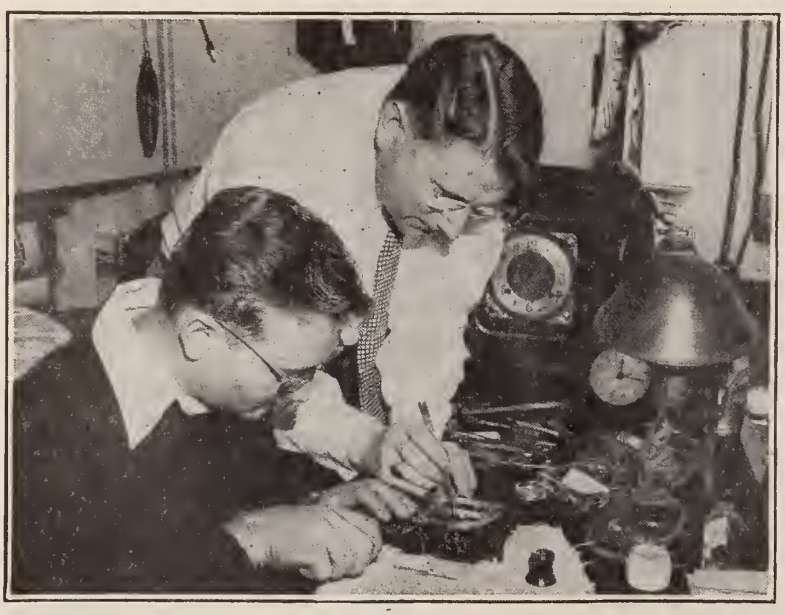
The Vocational Rehabilitation Division of the State Board of Vocational and Adult Education, which administers the law, would like to help you with the problem of the patient who is handicapped for employment. Its eight offices are located in vocational schools at Green Bay, Madison, Milwaukee, Eau Claire, Superior, Wausau, La Crosse and Racine.

All men and women of working age with substantial mental or physical health handicaps are eligible for aid. Any help the patient gets is based on the doctor's diagnosis, prognosis and recommendations. A medical examination determines the degree of vocational handicap, how much to restrict physical activity and how far to go with the training program. The vocational counselor for a cardiac patient learns from the physician whether the patient may climb stairs, is of college calibre or must be content with a desk job. With a multiple-sclerosis patient seeking a more suitable job, the doctor tells how much re-training can be done in light of future progress of the disease.

Job Placement

Physical restoration programs are less difficult. They permit corrective surgery or therapeutic treatment for stable conditions yielding to treatment within a reasonable period of time. This provides for removal or reduction of many handicapping difficulties such as cleft palate, hairlip, orthopedic difficulties, hernia and amputations. Treatment of acute or chronic conditions are ruled out.

Through use of psychological tests and the vocational counselor's knowledge of employment conditions, the patient may be guided from helplessness to a useful occupation suited to his particular capabilities and physical requirements. Public Law 113 and the Vocational Rehabilitation Division make possible a satisfying adjustment of his problem—and the doctor's.



A Wisconsin polio victim in apprenticeship training after having had rehabilitation care and training. Public Law 113 aids doctors in handling such cases. Its benefits include corrective care, orthopedic training and vocational placement—all on the doctor's recommendation.

Can't Fool Public, Doctors Warned at the Midwest Regional Conference

The medical profession must make its accomplishments clear, its policies unassailable and its program so solid and concrete that it can neither be ignored nor distorted, Mr. Lester H. Perry, executive secretary of the Medical Society of Pennsylvania, told more than 200 doctors attending a public relations forum at the Midwest Regional Conference held in Cleveland, Jan. 4.

The discussion included Mr. Hugh W. Brenneman, public relations counsel for the Michigan state medical society, and Mr. George H. Saville, director of public relations of the Ohio state medical society, with Dr. James H. Hutton of the Illinois state medical society acting as moderator.

Need Good Works

"Physicians must be willing to submit to truth, candor and frankness, otherwise their public relations will degenerate into an attempt to fool the people—and the people do not enjoy being fooled," Mr. Perry warned.

"Public relations cannot be wrapped up in a package and delivered," he said. "It is neither a cover nor shortcomings nor a substitute for good works. If the activities of medical societies or the efforts of individual physicians are characterized by fumbling, confusion and selfishness, no man alive can do a good job of public relations for the profession."

Medical Impractices

Mr. Brenneman declared that the probabilities of success in medical public relations depend largely upon the skill and extent to which doctors will use the tools available to them. Medical impractices, such as refusal to answer night calls and overcharging, are the greatest menace to medical public relations, he said.

Mr. Saville asked that county medical societies become the family doctors of their communities and called for greater cooperation of local, state and national medical groups with welfare and health agencies.

Meetings of Wisconsin's "little legislature," newly created joint legislative council, are already being held in Madison. Charged with doing much of the spadework in advance of the next regular legislative session, the council evaluates subjects meriting legislative action, collects and compiles data and assists in drafting bills for introduction.

Hearings on proposals pending before the council or any of its nine subcommittees are open to the public. Chairman Warren P. Knowles says that they "will listen to anyone concerned with new legislation."

Office of the council is in the state capitol and in charge of Philip S. Habermann, executive secretary. Address communications and suggestions to that office.

* * *

At a Health and Accident Underwriters conference in Chicago, Feb. 5, it was learned that an insurance company will soon initiate a full pay hospital plan in a southern state . . . Use of a uniform assignment blank was recommended after the underwriters considered nearly a dozen types . . . Also discussed at the meeting were new developments in hospital benefits such as anesthesiologists and radiologists requesting anesthesia and x-ray coverage independent of hospital coverage, and the requirement by some hospitals of chest x-rays for all patients.

* * *

Congressman Glenn Davis, Waukesha, reports from Washington that he sent letters to every person whose name appeared on one of several petitions circulated in the Second District urging favorable action on various legislative bills before congress.

The results were "amazing," Davis said. "Some persons have written me that they never signed the petition in question. Others wrote that they were 'over-influenced' by associates, signed against their will, and now want their names removed."

SAYS DRAFT FIGURES NO INDEX OF HEALTH

Hold Rural Health Conference

Chicago—Is a corpse healthier than a rejectee with diabetes? Dr. Maurice H. Friedman, Washington, D. C., posed this question at the 3rd annual rural health conference of the American Medical Association, Feb. 6–7, as he sought to prove that draft rejection figures for World War II are no indication of the health of rural people.

Citing acceptance rather than rejection figures, Dr. Friedman pointed out that rural acceptance rates were higher than city rates —54.7% from cities and 57.3% from rural areas. In the negro population, rural acceptance rates were slightly lower than city rates, with venereal disease, educational and mental deficiencies causing 60% of the rejections. He said that less than 5% of all rejections could have been prevented by medical care.

Pointing to amputees and others, Dr. Friedman said that a great many draft defects were not caused by lack of medical care, but were the result of it.

"The fact that diabetics and rheumatic fever victims lived long enough to walk to the draft board is a tribute to the profession," he declared. "Had the medical profession allowed these individuals to die through lack of care, the selective service figures would look good, but the death rate would be terrible."

Dr. V. M. Hoge, director of hospital facilities of the United States public health service, reported that 124 hospital projects have already been approved under the hospital survey and construction act, most of them in communities of 5,000 or less population.

At the 21st annual meeting of the national conference on medical service in Chicago on February 8, Everett W. Jones, vice president, Modern Hospital Publishing Co., and Dr. Lowell S. Goin, past president of the Radiological Society of North America, expressed opposing viewpoints on the practice of medicine by hospitals, health departments and medical schools.

Small pay, lack of recreation, administrative hierarchy, lack of retirement and social security benefits and the womanpower shortage are the major causes of the nursing shortage, stated Dr. Thomas P. Murdock, member of the AMA committee to study nursing service in America. He said the committee's report would be completed by June.

Janet Geister, R. N., consultant for American Association of Industrial Nurses, said that money alone would not solve the nursing "crisis", but greater cooperation between medical men, hospital administrators and nurses could eliminate most of the "gripes" of each.

Latest figures from the Wisconsin Unemployment Compensation division show that the division has 178 employees in its central office and 142 in its area offices—a total of 320. There are 655,000 persons covered under "unemployment comp." This means that there is one civil service employee for each 2,000 persons covered.

The quality of medicine which is at our beck and call cannot be valued in dollars and cents. If it could be, the price would be most reasonable.

However, when the doctor bill does arrive, it sometimes looks like the national debt to the individual who has to pay it in a lump sum.

Accident and Health, Hospital and Surgical Insurance helps soften the blow and keeps the patient on a paying basis.

It is our aim to pay all claims promptly. The attending physician can make his patient's disability insurance more efficient by the prompt dispatch of claim blanks covering the disability.

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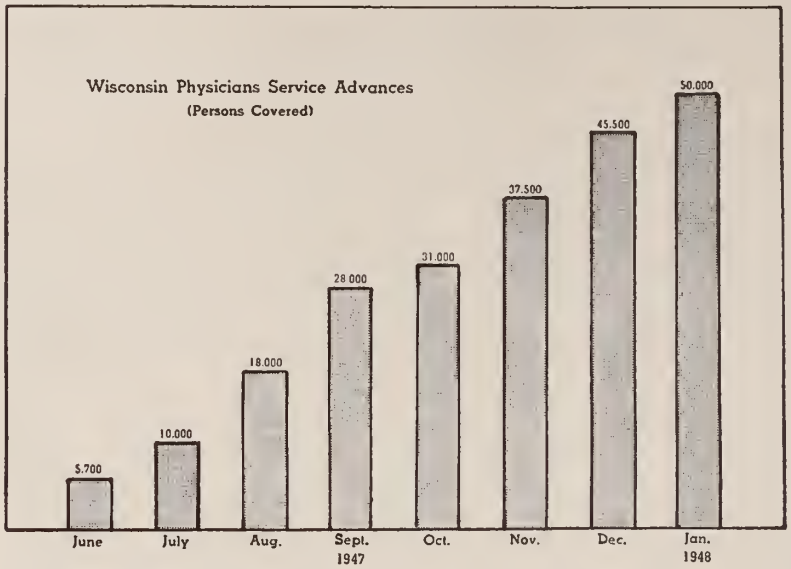

WISCONSIN PHYSICIANS SERVICE AND BLUE CROSS REPORT ON PROGRESS

Madison—Hospital and surgical services valued at more than $187,500 were rendered to subscribers who had Blue Cross–Wisconsin Physicians Service coverage during the period of May 1 to December 31, 1947, reports Ralph F. Weber, director of Wisconsin Physicians Service.

The actual total of $187,598.39 represents payments for 11,541 hospital days and 3,224 medical days plus surgical procedures performed under Wisconsin Physicians Service.

Of the total services rendered, Blue Cross paid $98,036.64 while Wisconsin Physicians Service paid $89,651.75, Mr. Weber stated. He pointed out that four major procedures accounted for more than 58% of all benefits paid under the medical–surgical schedule of Wisconsin Physicians Service.

Four hundred thirty-three tonsillectomies and adenoidectomies paid $15,040 or 16% of all benefits paid; 146 appendectomies took $14,600 or 16.3%; 171 gynecological procedures accounting for $12,720 or 14.2%, and 3,224 medical days answered for $9,672 or 10.8% of all benefits paid.

Mr. Weber also announced that Wisconsin Physicians Service has been given the Seal of Acceptance of the American Medical Association. He was advised of the action in a letter as follows:

"It is a pleasure to advise you that the Council on Medical Service voted at its last meeting to grant the Seal of Acceptance to 'Wisconsin Physicians Service.'

"In this instance, the Seal is granted pending recommendations and developments of the Special Committee in Wisconsin. Upon the completion of any new plan by the Special Committee, the Seal is to be withdrawn and an application from such a plan will then be considered."

The letter was signed by Thomas A. Hendricks, secretary of the Council on Medical Service of the American Medical Association.

Wisconsin Prepaid Plans Get Seal of Acceptance

The Seal of Acceptance of the American Medical Association was granted last month to the Wisconsin Plan and Wisconsin Physicians Service, two prepaid health insurance plans of the state medical society. The Seal was granted by the AMA Council on Medical Service.

4th OB–GYN Congress to Be International Meeting

The American Committee on Maternal Welfare, with headquarters in Chicago, has announced plans for an international congress on obstetrics and gynecology to take place on May 14–19, in 1950.

The international meeting will also include the Fourth American Congress on Obstetrics and Gynecology, Dr. Fred L. Adair, chairman of the Congress, revealed. The meeting will be held at the Hotel Pennsylvania in New York City.

Chiropractors After Public Confidence

"More than fifty years of definite service to the sick, bringing with it more than 30,000,000 people who look to Chiropractic for their health, has crystallized into a great national program which will affect all mankind. Dr. Bishop, as Publicity Chairman of the Chiropractic Research Foundation's 9-point development program, outlines the aims and plans of this worthy program."

With this introduction, Neal Bishop writes that "Chiropractic Looks Up" in the December, 1947 issue of the *"Chiropractic Home."* He reports on a new chiropractic program designed to "inspire public confidence," provide all graduates of chiropractic colleges with uniform educational background and set up a recognized code of ethics.

Million Dollar Fund

The aims of this program are:

1. Intensive, nationwide publicity and advertising to bring good-will and "recognition to the profession for its past accomplishments" and to inspire the "confidence this profession deserves."

2. Set up "modern, progressive chiropractic hospitals and sanitaria" in principal regions of the United States.

3. Organize a lay organization to work for chiropractic recognition. Its goal is a million members with a multi-million dollar fund to support a Chiropractic Research Foundation on a national, regional and local basis.

Plan 15 Colleges

4. Start research laboratories "manned by brilliant chiropractic research specialists" who will "probe for hidden causes of disease and develop curative measures."

Other measures include the founding of 15 chiropractic colleges within five years, some of which are to be "integral parts of large universities;" raise $9,000,000 to build hospitals and carry out the program, and unify the profession.

New Policies for Wisconsin Plan by May 31; Competition to Set Premium Rate Structure

The Wisconsin Plan of Prepaid Surgical, Obstetric and Hospital insurance has entered a new phase in its development as an agency to extend voluntary protection against the costs of medical care to the people of Wisconsin.

As the result of recent sudies and conferences between the state medical society, sponsors of the plan, and private insurance companies who operate the plan, new objectives, principles, specifications of coverage and fee schedules will go into effect no later than May 31.

The seven-man Committee on Extension of Insurance which supervises the plan for the medical society has announced that it is no longer necessary to maintain complete control over the premium rate structure of the Wisconsin plan and that the premium rates will be left to find their natural level by competition among the insurance companies who sell the plan.

Minimum Standards Set

This action is partly the result of a federal court decision which may make control of premiums a violation of anti-trust laws. Committee Chairman Dr. H. H. Christofferson, Colby, said that enrollment (nearly 100,000) and publicity are now sufficient to assure the public of a fair rate for benefits obtained, and assure the profession that administrative costs will be held within reasonable limits.

"Experience of all companies can be obtained periodically, so that the committee, the profession and the public can be assured that benefits paid bear a proper relation to the cost of the program," Dr. Christofferson said.

Doctors Can Check Progress

A new schedule of benefits to be effective May 31 will make Wisconsin Plan and Wisconsin Physicians Service, another prepaid plan of the society, almost completely identical as to fee schedules.

Because of variations in methods of extending coverage, the committee will no longer require each insurance company's policy to be the same, but will set minimum standards which each policy must meet. Income levels for full coverage will remain at $2,000 for persons without dependents and $3,600 with dependents.

All insurance companies licensed to write health and accident coverage in Wisconsin have been informed of these developments and invited to participate in the program. Each company will submit its policy for review and approval by the committee before it may be sold as the Wisconsin Plan.

REGULAR NAVY OPENS RANKS TO DOCTORS

Civilian doctors may now become commissioned officers in the regular Navy provided they meet professional and physical qualifications, the Navy Bureau of Medicine and Surgery announced recently.

A law passed by the last Congress did away with the age limitation of thirty-two and permits doctors in civilian practice to enter the Navy at ranks up to and including Captain. The law applies to internes, residents, reserves, resigned medical officers and practicing physicians.

An applicant must be a citizen of the United States, graduate of a Class "A" medical school, and have served at least one year's internship in an approved hospital. Candidates will be judged on several qualifications, including member of specialty board; military service, etc. Rank will be given according to academic age, professional standing and experience.

Doctors interested in such a career may write the Bureau of Naval Personnel, via the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

Industrial Nurses Hold Institute in Milwaukee

Emotional Behavior on Agenda

The program for an Industrial Nurses' Institute being held Friday and Saturday, March 12–13, at the Hotel Pfister, Milwaukee, was announced by Dr. Paul A. Brehm, supervisor of the industrial hygiene unit of the state board of health.

Blood Center Operation

"The Importance of the Industrial Nurse in Public Relations," will be discussed by William Nunn, Ph. D., of the University of Minnesota at 9:45 a. m. Friday. At 1:30 p. m., Friday, Dr. Tibor Greenwalt, director, Junior League Blood Center, Milwaukee, will describe activities of a blood center. He will be followed by Dr. Lydia Giberson, industrial psychiatrist of Metropolitan Life Insurance company, New York, speaking on "Problems Which the Industrial Nurse Meets in Emotional Behavior."

Cardiac Cases

Dr. William D. Stovall, director of the state laboratory of hygiene and president of the state medical society, will preside over the evening meeting at which Dr. Jean Spencer Felton, superintendent of the health department of Monsanto Chemical Co., Oak Ridge, Tenn., will speak.

Topics for the Saturday morning session are "Management of Cardiac Cases in Industry," by Dr. Chester Kurtz, Wisconsin General Hospital, Madison; and "Treatment of Industrial Injuries," by Dr. William Frackelton, Marquette University School of Medicine.

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Hawley to Coordinate Blue Cross–Blue Shield; Bortz Sounds Warning

Dr. Paul R. Hawley, who reorganized and developed the medical–hospital program of the Veterans Administration, announced on January 10 that he wanted no part of government control of medical practice for the American people.

He made the statement as he accepted the appointment as chief executive officer of the national organization of non-profit Blue Cross plans and Blue Shield medical–surgical service plans. He will assume his duties on April 1. Blue Shield was formerly Associated Medical Care Plans, Inc., (AMCP), and Dr. Hawley will coordinate the enrollment activities of 91 hospital plans and 48 medical–surgical plans.

Only One Objective

Stating that government operation of prepaid health plans was invariably coupled with government control of medicine, Dr. Hawley said, "I would not object to government control of medicine if this would elevate the standard of medical practice in this country. But I have seen government medicine in operation in other countries, and I know what government control does to medicine. I want no part of it for our people."

Dr. Hawley said that Blue Cross and Blue Shield have only one objective—"that of offering the best in prepaid health service at the lowest possible cost. These organizations have been operated for the benefit of the patient—not for the benefit of the doctor or the hospital. And so long as I am in any way connected with these organizations, there will be no deviation from this fixed policy."

Advance With Caution

At the same meeting Dr. Edward L. Bortz, president of the AMA, commended the Blue Cross plans and the medical–surgical plans developed by the state and county medical societies.

"The utilization of private sickness insurance plans which comply with the state regulatory statutes and the standards of the Council on Medical Service of the AMA is to be encouraged," Dr. Bortz said. "It is important to keep in mind that we are blazing new trails in the field of medical service, and, likewise, in the insurance field. Certainly many visionary suggestions, impractical of application, need to be critically surveyed before they are approved."

COMMENTS FROM THE WISCONSIN PRESS

Words of praise for family doctors came from *The Milwaukee Journal* on January 11, when the newspaper published a stirring editorial concerning their kind. The following editorial, printed with permission of *The Milwaukee Journal*, was accompanied by a picture of Sir Luke Fildes renowned painting, "The Doctor."

The Family Doctor Comes Into His Own

"Belatedly, the family doctor is being formally honored by his professional colleagues. The American Medical Association has picked "the family doctor of the year" and bestowed on him a gold medal and a fitting citation.

It is probably more than a coincidence that the first family doctor to be so honored was also a country doctor, who had ministered to the ill in a sparsely populated, rugged and isolated mountain community in Colorado for 21 years. It is under such circumstances that the family doctor must be at his valiant, untiring, resourceful and unselfish best. It was of such a doctor that Walter B. Pitkin remarked:

'A country doctor needs more brains to do his work passably than the 50 greatest industrialists in the world require.'

But the family doctor, for all his responsibilities, has gradually been relegated to the position of the Cinderella in his professional family. The specialists, the research men, the teachers and the consultants have become the glamor boys. They have reaped the lion's share of honors and publicity and the pretty scrolls in Latin and gold seals to decorate their office walls. The specialists have taken the cream of the financial rewards, too.

The family doctor has been left with the drudgery, the routine, the minimum and uncertain income. The undying loyalty and respect of his patients has been about the highest compensation to which he could aspire.

Now, once a year at least, a family doctor is to enjoy the professional attention and acclaim for a fleeting moment. A news dispatch says that the American Medical association has instituted this annual reward to help 'restore the family doctor to his traditional position in American life.'

The good family doctor, the kind who was pictured in Sir Luke Fildes' famous painting and the kind that most of us remember from childhood days, deserves this recognition and much more. With better recognition of its importance, the role of the family doctor—the family friend and mentor —may prove more attractive to the bright and ambitious young graduates of our medical schools."

Cancer Grant Goes to Marquette University

Milwaukee—A grant of $25,000 was awarded last December to Marquette University School of Medicine as one of the 64 colleges, laboratories and public health institutions receiving sums from a million and a half dollar grant of United States Public Health Service funds.

Marquette's grant is to be used for the improvement of cancer teaching in the medical school curriculum. Other schools received similar grants for cancer teaching, research or building construction.

T–B Association Sets Up Tuberculosis Fellowships

New York—A number of teaching and research fellowships in the field of tuberculosis have been established by the National Tuberculosis Association.

Annual stipends for the fellowships will range from $2,400 to $3,200 and provision will be made for laboratory fees and incidental expenses.

Fellowships will be limited to graduates of American schools for work in the United States. Applications will be considered in the fields of pathology, bacteriology, clinical medicine, epidemiology and social and statistical research.

Persons interested should write to Dr. James E. Perkins, managing director, National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

Medical Examiners License 259 in '47

Licentiates Barely Outnumber Doctors Leaving Practice

In the first article of this series, printed in the December Forum, we announced an article would be printed in this issue concerning the Trager Laboratories case in Milwaukee. However, an excellent write-up of this case was printed in that issue and although there is nothing for us to add to the story, we wish to express our appreciation to Milwaukee District Attorney William J. McCauley and his staff and to the Better Business Bureau of Milwaukee, without whose assistance this case could never have been concluded.

The Board of Medical Examiners feels that it should report each year the results of its activities in the field of licensure of doctors of medicine and surgery and doctors of osteopathy and surgery. Examinations for both groups are identical in all subjects except those of Materia Medica and Principles and Practice of Medicine. The osteopaths are not required to take examinations in Materia Medica and instead of Principles and Practice of Medicine, these applicants are examined in Principles and Practice of Osteopathy.

A summary of the year's work reveals that 255 doctors of medicine and surgery were licensed during 1947. Four applicants were licensed to practice osteopathy and surgery. Of the 255 licensed to practice medicine and surgery, 132 were licensed by written examination, 123 by reciprocity from other states or the armed forces. Two osteopaths were licensed by written examination, two by reciprocity.

An analysis of the records of the medical men shows that they were graduates of 45 medical schools in the United States and one Canadian school. No graduates of foreign schools except Canada were accepted for licensure according to the established policy of the Board.

During 1947 records show that 149 Wisconsin physicians were endorsed by this office to other states. There were about 90 deaths in the ranks of the profession during the year. This makes a total of 239 physicians known to be removed from practice.

While there is no way to arrive at the exact figure, it is estimated that an added 10 per cent of the doctors licensed in this state through reciprocity obtain license because Wisconsin statutes require hospital residents to be licensed. These men usually return to their home states to practice after finishing their residencies. There is also no way to correctly estimate the number of doctors who retire from active practice each year because of age, physical disabilities or other reasons.

Balancing these known and estimated figures against the number of 1947 licentiates, it is apparent that in spite of increased licensure activities of this Board, the actual increase in the number of permanent Wisconsin physicians is small.

Directs 1948 Cancer Drive in Wisconsin

The appointment of Oscar T. Jacobsen, Racine, as 1948 campaign chairman for the Wisconsin Division, American Cancer society, to direct the drive for funds in April, was announced recently by the board of directors of the Division.

OSCAR T. JACOBSEN

Mr. Jacobsen is president of the Jacobsen Manufacturing company, Racine. He served in the United States Marine Corps in World War I. Since then he has been affiliated with many civic and fraternal organizations and has done effective work for the general good by serving as a member of the Racine school board and the city planning commission.

His interest in the health and welfare of his fellowmen qualifies him for the post of state chairman of the cancer campaign.

MORE NURSES NOW THAN EVER BEFORE

Bureau of Nursing Education Reports Record Enrollment for Peacetime

Madison—A record peacetime enrollment of 2,167 student nurses in Wisconsin's 24 schools of nursing is reported by Miss Adele G. Stahl, director of nursing education of the State Board of Health. This figure indicates an increase of nearly 500 over the number of nurses 10 years ago, and 337 over the previous peacetime high in 1940.

Miss Stahl pointed out that 836 new student nurses were admitted to schools in 1947 while only 725 were admitted 10 years ago. During 1944 when war patriotism ran high and virtually all a nurse's training could be obtained free, the total enrollment was 2,669. Miss Stahl emphasized, however, that during the war the withdrawal rate of these students ran as high as 35% to 40%.

Today the withdrawal rate in Wisconsin is 20% or less, giving the state one of the lowest such rates in the United States. The national average is 34% to 35%.

Articles Hinder Recruitment

Answering the cry that there aren't any nurses, Miss Stahl reported that the number of nurses currently registered in Wisconsin has more than tripled in the last 20 years. In 1927 there were 3,074; in 1937 there were 5,497 and on Dec. 23, 1947 there were 9,596 registered nurses in the state. This does not include nurses with emergency permits, she said.

Nurse recruitment efforts under the direction of Miss Anita Kietzman, recruiting officer, have had encouraging results, Miss Stahl reports, but could become much more effective with greater aid from the Woman's Auxiliary of the state medical society, Parents Teachers associations, and others.

Biased, distorted articles in national magazines and poor wage and working conditions are hindering the procurement of sufficient top-quality nursing care, Miss Stahl declared. The average nurse's wage in Wisconsin is about $40 for a 44-hour week, she said, with one in every four nurses earning less than $145 a month and working 50 or more hours a week.

Colorado Sets Pace for Medical Public Relations

VA Praises Service of State Physicians

More Complete Reports Needed

"Wisconsin physicians have been of inestimable service to the state's veterans and the VA, both in treatment and claims work, and their efforts are deeply appreciated," John P. Cullen, Wisconsin regional manager of the VA, recently informed the Wisconsin Veterans Medical Service agency of the state medical society.

Mr. Cullen pointed out, however, that incomplete medical reports, furnished by physicians to support veterans' claims, are causing difficulties both for the veterans and the VA. He asked that physicians give additional assistance to the VA in this regard, so that the veteran may be served more effectively.

Medical statements which do not include a basis for the diagnosis set forth are valueless as evidence and cannot be accepted by the VA rating specialists as proof that a disability exists, Mr. Cullen said. He pointed to such statements as:

"I examined John Jones on Sept. 25. He had malaria."

In such a case, there is no choice but to ask for further evidence, Mr. Cullen stated. The statement should have included a definite diagnosis, declared history, physical findings, laboratory reports, constitutional symptoms and treatment prescribed.

Inadequate reports have been most numerous in malaria cases, he said. Before a malaria claim can be allowed, the claim must fulfill at least one of the following requirements: (1) record of the disease during service; (2) diagnosis within one year after discharge, plus a record of service in an endemic area. In exceptional cases service-connection may be granted after one year; (3) notation at discharge that a malaria attack was experienced in service, plus a record of service in an endemic area.

Rates of compensation for malaria depend on the number of proved relapses following service or on the severity of residuals, such as enlargement of the spleen, anemia or others.

Stress Self-Discipline, Fees and Public Service

Denver, Colo.—Complete revision of the Colorado Medical Society's procedure for self-discipline of the medical profession in that state is hailed as the most important single feature of a recently adopted program to "make Colorado first in health."

HARVEY T. SETHMAN

This is just one part of a revolutionary program that has won immediate and whole-hearted public approval, according to Harvey T. Sethman, executive secretary of the state society, reporting in the December, 1947, *Rocky Mountain Medical Journal.*

To do the job, the society created a Board of Supervisors described as a "grand jury empowered to receive complaints from any physician or layman against any doctor in Colorado in cases of misconduct, violation of professional ethics, overcharging, or any other complaint of individual or public dissatisfaction."

The new board may start investigations and may prefer and prosecute charges before any appropriate judicial body inside or outside of the society. It is believed that the Board will provide "a protection of physicians against unjust accusations that they, as individuals, would be unable to undertake."

The Colorado doctors say that "there is no denying that failure of a profession to regulate itself leads, through the passage of corrective legislation, to greater government control."

Acting to overcome the belief of the public that medical costs of all types of illnesses are wholly unpredictable, the Colorado house of delegates directed that all county societies formulate and publicize "average" fee schedules for their local communities.

These fee schedules are not intended to regulate the maximum or minimum fee that any physician should charge or that any patient should pay. Instead, they will inform the public what the "reasonable average charge is for uncomplicated cases in any given community, based upon the judgment of all the member physicians in the area covered by each schedule."

Coupled with these actions is a completely revitalized program of public health and service. Each local society was directed to identify the most serious health problems in its community and to set up the necessary committees and take positive action to solve them in order of their importance.

A proposal that the state society sponsor "a state-wide network of detection centers to discover all diseases and correctable health conditions . . . and then systematically refer the persons needing attention to the medical profession for further diagnosis and treatment" was not approved.

Form Medical Disaster Group

Other public health and service features of the program include a society sponsored state-wide service for rehabilitation of civilians suffering from physical handicaps; establishment of an endowed, nonprofit private neuropsychiatric institute in the Denver area and improved care for these persons all over the state; formation of a medical disaster commission to meet epidemic, military and other emergencies, and improved programs of rural and industrial health.

In still another fashion, the society "departed distinctly from previous tradition", Mr. Sethman states. "Rather than discouraging the use of physicians' names in the press and on the radio, the House adopted a recommendation that these media be encouraged to quote society officers, committee chairmen and other physicians officially appointed by the State or component societies as spokesmen, on all matters of public interest."

E. L. BELKNAP, M. D.
Milwaukee

Counties Plan In-Plant Industrial Health Clinics

P. A. BREHM, M. D.
Madison

Six counties in the industrialized areas of the state are conducting industrial health clinics during the next three months. The clinics are being developed by industrial health committees of the various county societies, in cooperation with the Industrial Health Committee of the State Medical Society and the Industrial Hygiene Unit of the State Board of Health.

While present plans are in the tentative stage, the following schedule has been agreed upon:

March 31: Rock County: G. H. Peterson, M. D., Beloit, Chairman.

The Fairbanks–Morse Plant at Beloit will be visited between 2:00–4:00 p.m., followed by a review of industrial hazards by E. L. Belknap, M. D., Milwaukee, and Paul A. Brehm, M. D., director of the Industrial Hygiene Unit of the State Board of Health, who will serve as medical consultants.

A dinner meeting will be held, with industrial nurses, insurance carriers, representatives of management and labor, and physicians in attendance. A prominent industrial leader will be chosen as one of the speakers. The second speaker will be Mr. Harry Nelson, director of the Workmen's Compensation Division of the State Industrial Commission.

April 15: Outagamie and Winnebago Counties: J. B. MacLaren, M. D., Appleton, and T. D. Smith, M. D., Neenah, joint chairmen.

The Kimberly–Clark mill at Neenah will be visited between 2:00–4:00 p.m., followed by a scientific session under the direction of Doctor Brehm as one of the consultants.

A dinner meeting for physicians, industrial nurses, insurance carriers, and representatives of management and labor is being planned. Speakers to be announced.

April 21: Racine and Kenosha Counties: R. M. Kurten, M. D., Racine, chairman.

While plans are still in a formative stage the program will follow the same general pattern of the Rock County clinic described above. The clinic will be held in Racine. Details will be released to all members of the Racine–Kenosha societies and adjoining medical societies within the next month.

May 6: Dane County: J. W. Brown, M. D., Chairman.

Plans are still in the formative stage, but it is possible that the Gisholt Machine Company will be selected for visitation. Details will be sent to all members within the next month.

While the above clinics have been planned under the active sponsorship of the various county medical societies in cooperation with the Industrial Health Committee of the State Medical Society, the meetings are open to all physicians who are interested in industrial practice. The viewing of industrial hazards "on the job," so to speak, will contribute to a better understanding of the environment in which many patients are employed, and will serve to indicate to management and labor the interest of the medical profession in the general health problems of the community.

If you are not located in any of the counties serving as hosts for these clinics and wish to attend please communicate with the office of the State Medical Society, 917 Tenney Building, Madison 3, Wisconsin, and further information will be sent you as to program details and dinner arrangements.

Society Proceedings

Ashland-Bayfield-Iron

At the annual meeting of the Ashland–Bayfield-Iron County Medical Society on December 17, *Dr. Homer D. Baird* of Montreal was named president for 1948. *Dr. A. H. Lamal* of Ashland was elected secretary-treasurer, and *Dr. L. W. Moody* of Bayfield, vice-president. Delegate to the State Medical Society for the coming year is *Dr. John W. Prentice*, of Ashland; *Dr. W. E. Bargholtz*, also of Ashland, will serve as alternate delegate.

Brown—Kewaunee—Door

Meeting at the Beaumont Hotel in Green Bay on January 8, members of the Brown–Kewaunee-Door Medical Society heard *Dr. George S. Kilkenny* of Milwaukee speak on "Obstetrical Emergencies." Doctor Kilkenny is associate professor of obstetrics at Marquette University School of Medicine. *Dr. A. B. Grant*, resident physician in obstetrics at St. Joseph's Hospital in Milwaukee, discussed "Nupercaine Spinal Anesthesia in Obstetrics."

The annual business session of the Society was held at the Chalet in Green Bay on December 9. *Dr. W. W. Ford* of Green Bay will head the group as president during the coming year. Assisting him in office will be *Drs. E. M. Jordan*, Green Bay, president–elect; *D. E. Dorchester*, Sturgeon Bay, vice-president; *G. M. Shinners*, Green Bay, secretary-treasurer; *J. J. Robb* and *P. F. Dockry*, Green Bay, censors; *O. W. Saunders* and *A. J. McCarey*, both of Green Bay, delegates; and *W. P. Tippet* and *W. A. Killins*, also of Green Bay, alternate delegates.

Dr. Ovid O. Meyer of Madison discussed "Hemorrhagic Diseases" at the December session. Doctor Meyer is professor of medicine at the University of Wisconsin Medical School.

Calumet

At the November meeting of the Calumet County Medical Society, *Dr. W. A. Langmack* of Brillion was named president. Other officers elected were *Drs. F. P. Larme*, New Holstein, secretary–treasurer; *A. C. Engel*, New Holstein, delegate; and *E. W. Humke* of Chilton, alternate delegate. *Drs. N. J. Knauf* of Chilton and *R. J. Winkler* of Hilbert are on the board of censors.

Chippewa

Dr. Earl Hatleberg of Chippewa Falls was chosen to head the Chippewa County Medical Society at the annual meeting of the group on December 16. The meeting was held at Hotel Northern in Chippewa Falls. Serving with the new president will be *Drs. Lyman Picotte*, Chippewa Falls, vice-president; *R. K. Salter*, Cadott, secretary; *S. E. Williams*, Chippewa Falls, delegate; and *J. J. Sazama*, Chippewa Falls, alternate delegate.

Dr. S. E. Williams, who attended a series of nine medical meetings during the past year, gave a report on late developments in medicine and surgery as discussed at those meetings.

Clark

Medical and surgical aspects in the treatment of ulcer were discussed at the January meeting of the Clark County Medical Society. *Drs. F. G. Anderson* and *A. J. Klein*, both of Eau Claire, were the speakers at the dinner meeting, which was held at the Silver Dome near Neillsville on January 15.

Columbia—Marquette—Adams

The Owl's Nest at Poynette was the meeting place of the Columbia–Marquette–Adams County Medical Society on January 13. A business meeting was held, and committees were set up for the coming year.

Douglas

Drs. Ivan T. Clark and J. R. McNutt, both from the staff of St. Mary's Hospital in Duluth, Minnesota, spoke on "Interesting Studies of Roentgenological Nature" at the January meeting of the Douglas County Medical Society. The group met at Hotel Superior in Superior on January 7. Discussants of the evening's topic were *Drs. R. P. Fruehauf* and *V. E. Ekblad*, both of Superior. The new V. A. fee schedule was discussed.

The Auxiliary met with the Society for a dinner party on December 3 at Hotel Superior. The practices of osteopaths, chiropractors, etc., were discussed, and a report is to be made to the State Medical Society.

Grant

Dr. William J. Kelly of Potosi was named president of the Grant County Medical Society at a meeting of the group on November 2. Other physicians who were named to office were *Drs. James D. Glynn*, Lancaster, vice-president; *H. W. Carey*, Lancaster, secretary–treasurer; *James D. Glynn*, Lancaster, delegate; and *M. W. Randall*, Boscobel, alternate delegate.

Green Lake—Waushara

Meeting at Berlin Memorial Hospital in Berlin on December 10, members of the Green Lake-Waushara County Medical Society heard staff members of the State Medical Society discuss medical economics. Speakers were Mr. C. H. Crownhart, secretary of the Society; Mr. Thomas J. Doran, director of Wisconsin Veterans Medical Service

Agency; Mr. Ralph Weber, director of Wisconsin Physicians Service; and Mr. Earl Thayer, executive assistant.

Officers for 1948 were named as follows; President, *Dr. H. C. Koch*, Berlin; vice-president, *Dr. A. A. Beck*, Wautoma; secretary–treasurer, *R. C. Darby*, Wautoma; censor, *R. Hong*, Wild Rose; delegate, *Dr. L. J. Seward*, Berlin; and alternate delegate, *Dr. Mildred Stone*, Berlin.

Jefferson

Meeting at the Carlton Hotel in Watertown, members of the Jefferson County Medical Society heard a talk by *Dr. Edgar S. Gordon*, Madison, on January 22. Doctor Gordon, associate professor of medicine at the University of Wisconsin Medical School, spoke on "Radioactive Iodine in the Treatment of Thyroid Disease."

Meeting at the Jefferson House in Jefferson, members of the Jefferson County Medical Society chose their officers for 1948 on December 18. *Dr. H. G. E. Mallow* of Fort Atkinson was named president; *Dr. C. J. Garding*, Jefferson, vice-president; *Dr. R. W. Quandt*, also of Jefferson, secretary-treasurer; *Dr. A. C. Nickels*, Watertown, delegate; and *Dr. C. J. Garding*, Jefferson, alternate delegate.

On November 20, meeting at Forest Lawn Sanatarium in Jefferson, the group heard Dr. Edwin R. Levine, director of Chest Service at Michael Reese Hospital in Chicago, speak on "The Use of Antibiotics in Chronic Bronchial Infections." *Dr. A. C. Nickels* of Watertown, delegate to the annual meeting of the State Medical Society in Milwaukee, reported on the convention. The president appointed three members to arrange for a program honoring *Dr. H. O. Caswell*, Fort Atkinson, who has completed fifty years in the practice of medicine in Jefferson County.

Kenosha

Members of the Kenosha County Medical Society, holding their January dinner meeting at the Old Keno in Kenosha, on January 8 installed their officers for the coming year and heard a lecture by Dr. Lowell D. Snorf, professor of medicine at Northwestern University Medical School. *Dr. C. M. Creswell* was installed as president of the society for the coming year. Other officers include *Drs. Charles Ulrich*, president-elect; *Harold Kappus*, secretary; *W. C. Stewart*, delegate; and *George C. Schulte*, alternate delegate.

Doctor Snorf, in his talk, discussed the causes and treatment of hemorrhage from the intestinal tract, illustrating the talk with slides of clinical cases.

La Crosse

The La Crosse County Medical Society recently installed *Dr. Fred H. Wolf*, La Crosse, as president for the coming year. Other officers, also of La Crosse, who will serve during 1948 are *Drs. P. V. Hulick*, secretary-treasurer; *P. D. Anderson*, vice-president; and *C. F. Midelfort*, delegate.

Manitowoc

The present treatment of peptic and duodenal ulcers was discussed at a meeting of the Manitowoc County Medical Society on January 22 at the Hotel Manitowoc in Manitowoc. *Dr. Karver L. Puestow*, Madison, presented a paper on "Vagotomy and Its Relation to the Treatment of Duodenal and Gastric Ulcer." Doctor Puestow is professor of clinical medicine at the University of Wisconsin Medical School.

Marathon

The annual meeting of the Marathon County Medical Society was held on December 16 at Hotel Wausau in Wausau. The following officers were elected: president, *Dr. J. A. Jackson*, Mosinee; president-elect, *Dr. E. P. Ludwig*, Wausau; and secretary-treasurer, *Dr. A. W. Burek*, also of Wausau. The board of censors will consist of *Drs. W. T. Becker*, Wausau, chairman, *A. O. Hendrickson*, Wausau, and *C. Kampine*, Marathon. *Drs. R. C. Shannon* and *C. F. Johnson*, both of Wausau, will serve on the program committee with Chairman *D. M. Green*, also of Wausau. *Drs. G. R. Hammes* and *W. M. Rounds* of Wausau and *F. C. Kroeplin* of Stratford will serve on the public health and legislature committee.

Dr. M. C. F. Lindert of Milwaukee addressed the society on the "Mechanism of Production of Jaundice and Differential Diagnosis."

Marinette

The progress, present and future anticipation of the Michigan Physicians Plan was discussed at the December meeting of the Marinette County Medical Society by Mr. Cook, regional director of Michigan Medical Service. The meeting was held at Hotel Menominee in Menominee, Michigan, on December 17.

Meeting in Hotel Marinette in Marinette on November 19, members of the Society heard Mr. Ralph Weber, Milwaukee, speak on the Wisconsin Physicians Service plan, its organization, scope, premiums, and contract. Mr. Weber is the director of Wisconsin Physicians Service. Mr. George Nauert, assistant secretary of the Wisconsin Blue Cross Plan discussed the relationship of Wisconsin Blue Cross to Wisconsin Physicians Service. Officers elected at the November meeting are as follows: president, *Dr. C. H. Boren*, Marinette; vice-president, *Dr. Charles E. Koepp*, Marinette; secretary-treasurer, *Dr. Kenneth Moss*, Marinette; delegate, *Dr. Henry W. Haasl*, Peshtigo, and alternate, *Dr. K. G. Pinegar*, Marinette. The board of censors consists of *Drs. A. T. Nadeau*, *J. W. Boren*, and *Ralph B. Pelkey*.

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Outagamie

"Newer Trends in the Treatment of Blood Diseases" was the title of a paper presented by *Dr. J. S. Hirschboeck*, Milwaukee, at the meeting of the Outagamie County Medical Society held at the Conway Hotel in Appleton on January 15. Doctor Hirschboeck is dean of Marquette University School of Medicine.

Pierce—St. Croix

Members of the Pierce-St. Croix County Medical Society met on December 11 to elect the following officers for 1948: president, *Dr. Chalmer Davee*, River Falls; vice-president, *Dr. C. A. Olson*, Baldwin; secretary-treasurer, *Dr. C. E. McJilton*, River Falls; delegate, Doctor McJilton; and alternate delegate, *Dr. O. H. Epley*, New Richmond.

Polk

Members of the Polk County Medical Society met in Frederic on December 18 at the Theater Cafe to hear a discussion of medical economics by *Dr. G. J. Hathaway* of Superior; Mr. Thomas J. Doran, director of the Wisconsin Veterans Medical Service Agency; Mr. C. H. Crownhart, secretary of the State Medical Society; and Mr. Earl Thayer, executive assistant of the State Medical Society. Following the meeting, they adjourned to the home of *Dr. R. G. Arveson*, where the Auxiliary to the society met with them for refreshments. There Doctor Hathaway gave a talk on his experiences as a medical officer at Dachau.

Portage

At a dinner meeting at the Hotel Whiting in Stevens Point on December 16, the Portage County Medical Society held its annual business session, electing the following officers: president, *Dr. Stanley R. Miller;* vice-president, *Dr. F. C. Iber;* secretary-treasurer, *Dr. H. A. Anderson;* censor, *Dr. F. A. Marrs;* delegate, *Dr. E. E. Kidder;* and alternate delegate, *Dr. W. C. Sheehan.* All officers, with the exception of Doctor Anderson, who is located at River Pines Sanatorium, practice in Stevens Point. Doctor Kidder, delegate, reported on the annual meeting of the State Medical Society in Milwaukee in October.

Racine

Describing the neurosurgical approach to the relief of severe intractable pain in diseases of the head and neck, upper extremities, chest walls, and lower extremities, *Dr. David Cleveland* of Milwaukee spoke before the Racine County Medical Society on January 22 at the Racine Country Club. Doctor Cleveland, assistant professor of surgery at Marquette University School of Medicine, entitled his paper "The Treatment of Intractable Pain." The fee schedule committee gave its report and recommendations, both of which were accepted.

On November 20 the group elected its 1948 officers, the following physicians being named to positions: *Dr. R. W. Kreul*, president; *Dr. H. G. Brehm*, president-elect; *Dr. Paul R. Hahn*, vice-president; *Dr. William R. Kreul*, secretary-treasurer; *Drs. C. O. Schaefer* and *G. J. Schulz*, delegates; and *Drs. G. N. Gillett*, and *E. J. Schneller*, alternates.

Richland

At a meeting of the Richland County Medical Society on December 2, the following officers were elected: president, *Dr. K. H. Meyer;* vice-president, *Dr. L. M. Pippin;* secretary-treasurer, *Dr. Gideon Benson;* delegate *Dr. George Parke, Sr.;* and alternate delegate *Dr. George Parke, Jr.* Doctor Parke, Sr. is from Viola; the other officers are from Richland Center.

Trempealeau—Jackson—Buffalo

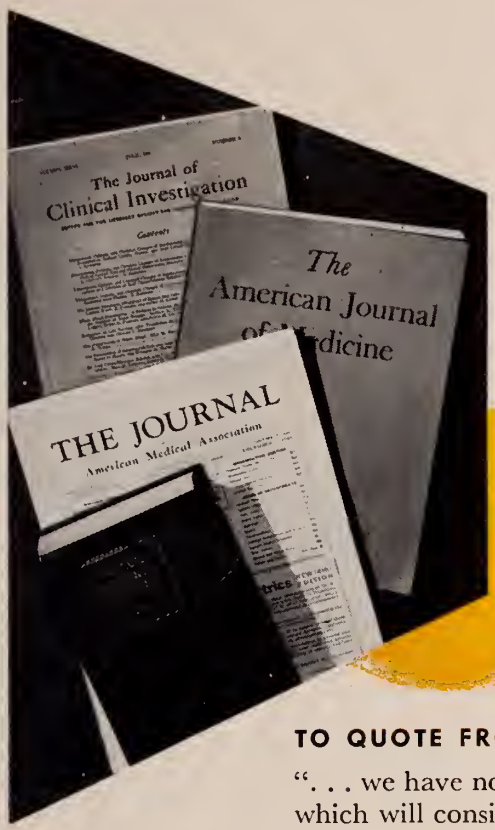
Dr. S. E. Williams of Chippewa Falls was the guest speaker at a meeting of the Trempealeau–Jackson–Buffalo County Medical Society at the MacCornack Clinic in Whitehall on December 18, relating the high lights of his trips to twenty-two medical meetings throughout the country. *Dr. B. C. Dockendorff* of Arcadia was installed as president and the following officers were elected: president-elect, *F. C. Skemp*, Fountain City; secretary-treasurer, *R. L. Alvarez*, Galesville; delegate, *R. L. MacCornack*, Whitehall; and alternate delegate, *Robert Krohn*, Black River Falls. *Drs. H. A. Jegi*, Galesville, *F. J. Gillette*, Mondovi, and *Robert Krohn* will serve on the board of censors. Doctor MacCornack gave his report as delegate to the annual meeting of the State Medical Society in October.

Washington—Ozaukee

J. W. RASTETTER

A joint dinner with the members of the auxiliary at the Republication Hotel in Kewaskum preceded the scientific and business meeting of the Washington–Ozaukee County Medical Society at St. Joseph's Hospital on January 22. Guest speaker for the occasion was *Dr. Joseph W. Rastetter* of Milwaukee, who talked on the "Physiology of Heart Failure."

At the November meeting of the Society, *Dr. Charles P. Kauth* of Port Washington was named president; those who will assist him in office are *Drs. E. L. Bernhardt*, West Bend, vice-president; *Richard H. Driessel*, West Bend, secretary-treasurer; *A. H. Barr*, Port Washington, delegate; and *T. D.*



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"... we have not found any therapy other than gold therapy which will consistently and in a high percentage of cases change the course of the disease."[1]

"Gold therapy at present seems to be the only drug which shows promise of checking the activity of rheumatoid arthritis; ...."[2]

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Gold Sodium Thiosulfate must be used with extreme caution, especially in the presence of tuberculosis and diseases of the liver and kidneys.

1. *Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: Am. J. Med.* 1:675 (Dec.) 1946.
2. *Comroe, B. I.: J.A.M.A.* 128:848 (July 21) 1945.
3. *Council of Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. B. Lippincott Company, 1947, p. 477.*
4. *Freyberg, R. H.; Block, W. D., and Levy, S.: J. Clin. Investigation* 20:401 (July) 1941.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

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Elbe, Thiensville, alternate delegate. A discussion of the new hearing clinics for school children being established in Washington and Ozaukee counties followed. *Dr. W. E. Grove* of Milwaukee, representing the Committee on Hearing Defects of the State Medical Society, and Mr. John Duffy of the State Bureau of Handicapped Children, were the guest speakers.

Walworth

Dr. C. Y. Wiswell of Williams Bay was named president of the Walworth County Medical Society at the January meeting held at the Lakeland Hospital in Elkhorn. Serving with him will be *Drs. H. F. Bischof*, Lake Geneva, vice-president; *R. S. Galgano, Delavan*, secretary-treasurer; *E. D. Sorenson*, Elkhorn, delegate; and *R. A. Mullen*, Burlington, alternate delegate.

Barron—Washburn—Sawyer—Burnett

Members of the Barron–Washburn–Sawyer–Burnett County Medical Society met at Rice Lake on December 8 to elect the following officers: president, *Dr. R. C. Thompson*, Cumberland; vice-president, *Dr. Dale Moen*, Shell Lake; and secretary, *Dr. J. B. Balken*, Chetek.

Waukesha

"Diagnosis of Heart Disease" was the subject of a paper presented before the Waukesha County Medical Society at a meeting on January 7 by *Dr. Howard L. Correll* of Milwaukee. The meeting was held at the Avalon Hotel in Waukesha.

The annual business meeting of the society was held in December at the Rogers Memorial Sanitarium, and the following physicians were named to positions for 1948: *Dr. W. D. James*, Oconomowoc, president; *Dr. Gwilym Davies*, Waukesha, vice-president; *Dr. F. L. Grover*, Hartland, secretary-treasurer; *Dr. W. B. Campbell*, Waukesha, censor; *Dr. F. J. Woodhead*, also of Waukesha, delegate; and *Dr. E. C. Van Valin*, Sussex, alternate delegate. After the meeting the members joined the auxiliary for a buffet dinner.

Waupaca

The infantile paralysis clinic plan was discussed at the meeting of the Waupaca County Medical Society held at the Elwood Hotel in New London on October 16. Speakers were *Drs. Henry Santina* and *A. M. Christofferson*, both of Waupaca.

At the business session, *Dr. C. P. Arnoldussen* was named president; *Dr. L. A. Hudson*, vice-president; and *Dr. J. W. Monsted*, secretary-treasurer.

Winnebago

"Disturbances of Growth in Infancy and Childhood" were pointed out by *Dr. Kenneth B. McDonough* of Madison at the January 8 meeting of the Winnebago County Medical Society, held at the Valley Inn at Neenah. Doctor McDonough is assistant professor of pediatrics at the University of Wisconsin Medical School.

Election of officers took place at the December meeting, which was held at the Athearn Hotel in Oshkosh. *Dr. E. B. Williams*, Oshkosh, was elected president; *Dr. P. T. O'Brien*, Menasha, vice-president; *Dr. M. H. Steen*, Oshkosh, secretary-treasurer; *Dr. G. R. Anderson*, Neenah, alternate delegate; and *Dr. B. J. Hughes*, Winnebago, delegate. The program for this meeting consisted of a symposium on chest lesions held in conjunction with the American College of Chest Physicians. *Dr. David Feld*, of Muirdale Sanitarium, Wauwatosa spoke on pulmonary blastomycosis; *Dr. George Jurgens*, also of Muirdale Sanitarium, spoke on cystic disease of the lung; and *Dr. Mischa J. Lustok*, Milwaukee, talked about pulmonary atelectasis. Dr. A. L. Banyai, director of the American College of Chest Physicians, also was present and made a few remarks.

Wood

Meeting in Wisconsin Rapids on December 9, members of the Wood County Medical Society heard *Dr. Wallace Nelson* of Wisconsin Rapids give a report of a case of neurofibroma of the neck. *Drs. Leland Pomainville* and *Roger E. Garrison*, also of Wisconsin Rapids, spoke on Wilms' tumor and hypernephroma.

Eau Claire—Dunn—Pepin

Dr. George S. Baker of Mayo Clinic, Rochester, Minnesota, gave a lantern slide and movie demonstration in connection with a paper entitled "Surgery of the Peripheral Nerves" at a meeting of the Eau Claire–Dunn–Pepin County Medical Society at the Elks Club in Eau Claire on January 26. Following a general discussion of the subject, *Drs. H. S. Fuson* and *C. H. Falstad* reported on the progress of a committee investigating the fee schedule for indigent patients.

Members of the Eau Claire–Dunn–Pepin County Medical Society met at the Elks Club in Eau Claire on December 18 for their annual Christmas party. Officers were elected, the following members, all from Eau Claire, being named to positions: *Dr. W. R. Manz*, president; *Dr. D. L. Dawson*, vice-president; *Dr. H. D. Nester*, secretary–treasurer; *Dr. W. O. Paulson*, delegate; *Dr. C. M. Ihle*, alternate delegate; and *Drs. R. A. Buckley* and *Julius Blom*, censors.

At the November meeting, also held at the Elks Club, two members of the staff of Marquette University School of Medicine presented papers: *Dr. J. S. Hirschboeck*, dean, discussed "New Trends in the Treatment of Blood Diseases," and *Dr. J. J. Gramling, Jr.*, assistant professor of surgery, spoke on the "Management of Bowel Obstruction."

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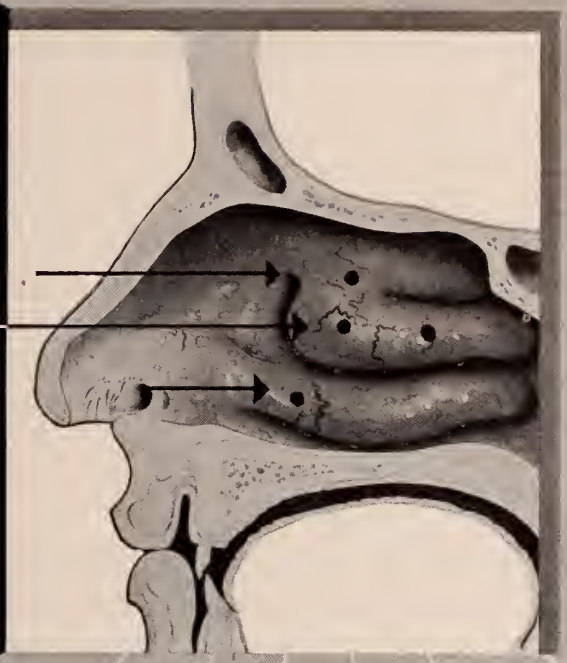

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Fond du Lac

Meeting at the Hotel Retlaw in Fond du Lac, members of the Fond du Lac County Medical Society heard a talk by *Dr. J. S. Hirschboeck* on January 22. Doctor Hirschboeck, dean of Marquette University School of Medicine, presented a paper on "Practical Aspects of Hematology in General Practice."

Wisconsin Heart Association

The Wisconsin Heart Association held its annual meeting on December 13 at Milwaukee County General Hospital. Dr. Horace M. Korns of Dubuque, Iowa, was the guest speaker for the occasion, addressing the afternoon session and the evening banquet.

Sheboygan

At a dinner meeting of the Sheboygan County Medical Society, held January 28 at Memorial Hospital in Sheboygan, officers were elected for the coming year. Those who will serve are *Drs. Edward T. Hougen*, president; *Joseph Kovacic*, vice-president; and *James F. Hildebrand*, secretary-treasurer.

Wisconsin Society of Anesthesiologists

Dr. Robert W. Wylde, Madison, was elected president of the Wisconsin Society of Anesthesiologists at its organization meeting which was held at the State of Wisconsin General Hospital on December 10. Other officers of the society, which has been granted a charter by the American Society of Anesthesiologists, Inc., are *Drs. Wilson Phillips*, Milwaukee, president-elect; *William Kreul*, Racine, secretary-treasurer; *Richard Foregger*, Milwaukee, delegate, and R. A. Tella, Milwaukee, alternate delegate. Directors include *Drs. May Davies*, La Crosse, J. B. Cushman, Milwaukee, *Paul Campbell*, Waukesha, *Gerald Shortz*, Milwaukee, and *Ralph M. Waters*, Madison. Doctor Waters was presented the distinguished service award for outstanding service in anesthesiology by the society.

News Items and Personals

Doctors Establish Clinic in Antigo

Drs. G. E. Moore and *J. W. Lambert* of Antigo will move to a new location in that community to establish the Moore and Lambert Clinic. They expect to occupy their new quarters, which are now being remodeled, about March 1.

J. F. Cary Attends Reunion Banquet

Dr. John F. Cary, Bay View, attended a reunion banquet of the officers of the Seventieth Division at Fort Leavenworth, Kansas, on January 17. The banquet was given in honor of their commanding officer who recently returned from overseas.

Superior Physicians Named Officers of Interurban Group

Dr. G. J. Hathaway, Superior, was named president of the Interurban Academy of Medicine at the annual election of officers in Superior in November. *Dr. R. T. Thompson*, also of Superior, was elected secretary-treasurer. The academy consists of physicians from Duluth and Superior, and meetings are alternated between the two cities.

Madison Physician Speaks at Eau Claire Hospital Conference

Dr. A. R. Curreri addressed a clinical-pathologic conference at Luther Hospital in Eau Claire on January 21. He also spent the day making rounds with members of the hospital staff of cases falling in his field. Doctor Curreri is associate professor of surgery at the University of Wisconsin Medical School.

R. B. Larsen Joins M. L. Jones in Practice

Dr. Roy B. Larsen last month became associated in medical practice with *Dr. Merritt L. Jones* at Wausau. Doctor Larsen, formerly of Madison, was chief resident in surgery at the State of Wisconsin General Hospital prior to his establishment in Wausau.

C. H. Falstad Named Chief of Staff of Luther Hospital

At the December meeting of the staff of Luther Hospital, Eau Claire, the following physicians were elected to office: *Drs. C. H. Falstad*, chief of staff; *S. L. Henke*, vice-chief; and *A. F. Haag*, secretary-treasurer. Members of the executive committee in addition to these three officers are *Drs. P. A. Midelfart* and *E. P. Hayes*.

N. L. Low Certified by Specialist Board

Dr. Niels L. Low, Racine, was recently certified by the American Board of Pediatrics. The examination was held in Dallas, Texas on December 6.

J. C. Kyllo to Head Superior Hospital Staff

Dr. J. C. Kyllo took over his duties as president of the medical staff of St. Joseph's Hospital in Superior on January 1. Other physicians who as-

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sumed office at that time were *Drs. R. P. Fruehauf*, vice-president; and *F. W. Reibold*, secretary-treasurer.

H. A. Jegi Portrayed as "Typical Family Doctor" by Publication

H. A. JEGI

Dr. H. A. Jegi, who recently was honored on the completion of fifty years of practice in Galesville, was selected by *The Crusader*, official magazine of the Wisconsin Anti-Tuberculosis Association to appear in the January issue as the "Typical family doctor." The complete edition was devoted to photographs of the doctor, showing him as an ordinary citizen as well a physician. Doctor Jegi served for many years as an officer of the Wisconsin Anti-Tuberculosis Association.

H. P. Baker Joins M. W. Stuessy in Practice

Dr. Homer P. Baker recently moved to Brodhead to become associated in practice with *Dr. M. W. Stuessy* of that community. Doctor Baker had been practicing in Blanchardville previously.

Lehmer-Shields Clinic Hospital Organized at Colby

Drs. G. G. Shields, Abbotsford, and *R. A. Lehmer*, Colby, recently purchased the Colby Clinic Building and have organized the Lehmer Shields Clinic Hospital. The doctors will be associated in the practice of medicine and surgery in the new organization, and Doctor Shields will maintain a part time practice in Abbotsford. Doctor Lehmer has been practicing in Colby since his discharge from the Navy in 1946.

J. F. Maser Named President of Hospital in Rice Lake

Dr. James F. Maser of Rice Lake was elected president of the staff of Lakeside Methodist Hospital, Rice Lake, at the annual meeting of staff physicians and surgeons in December. Other officers are *Dr. J. B. Balken*, vice-president, and *Lester Olson*, Spooner, secretary-treasurer. Doctor Maser replaces *Dr. R. W. Adams*, former president of the staff, who recently resigned.

Oneidas Adopt Indian Woman Physician

Dr. Lillie Rosa Minoka-Hill, 70 year old woman physician who last year was awarded the 1947 Indian Achievement award of the Indian Fire Council, was adopted by the Oneida tribe at ceremonies on Thanksgiving Day. The outstanding American Indian of 1947 was given the name "Youdagent"—she who serves—by the tribe of which her late husband was a member. The adoption was in recognition of her forty years of service in medicine to the tribe. Doctor Hill, a graduate of Women's Medical College in Philadelphia in 1899, became licensed to practice in Wisconsin in 1934.

Alexander Kremers Joins Staff of Central State Hospital in Waupun

Dr. Alexander Kremers, formerly of Kaukauna, recently joined the staff of Central State Hospital in Waupun. The doctor was employed as a physician at the Winnebago State Hospital prior to the establishment of practice in Kaukauna.

A. M. Ford Honored After Forty Years of Service in Roberts

Over 700 friends gathered at the Roberts High School in Roberts on November 13 to honor *Dr. A. M. Ford*, physician who has served that community for more than forty years. Among speakers who paid tribute to the doctor were *Dr. C. A. Dawson*, River Falls, who presented a gift in behalf of the Pierce–St. Croix County Medical Society; *Dr. S. E. Williams* of Chippewa Falls; and Dr. F. J. Plondke of St. John's Hospital in St. Paul. A program had been prepared in which a number of the doctor's "babies" participated, and a number of gifts were presented on behalf of the group.

The doctor graduated from Milwaukee Medical College in 1902 and organized practice in Roberts in 1908.

K. J. Denys Named Brown County Physician

Dr. K. J. Denys, Green Bay, last month was named Brown County physician by the board of trustees of county institutions to succeed the late *Dr. S. E. McNevins. Dr. Robert Burns* was reappointed physician for Hickory Grove Sanatorium.

Hospital in Fond du Lac Names 1948 Staff Officials

The staff of St. Agnes Hospital in Fond du Lac named *Dr. Adolph M. Hutter* chief of staff for the ensuing year at the annual business session on January 8. *Dr. J. S. Huebner* was elected secretary. *Dr. C. W. Leonard* was reelected chairman of the executive committee of the staff. Others on the committee are *Drs. E. V. Smith, Jr.*, and *E. H. Pawsat.* As the last year's chief of staff, *Dr. D. J. Twohig* automatically became the fourth committee member.

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—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Dane

"Amino Acid Therapy" was discussed at a meeting of the Dane County Medical Society on January 13 at the Madison Club. *Dr. Otto V. Hibma* presented a paper on the subject, and *Dr. J. P. Malec* led the discussion.

University of Wisconsin

Meeting in the auditorium of the Service Memorial Institutes Building on January 6, members of the University Medical Society heard a program presented by the cancer research group associated with the McArdle Memorial Laboratory of the University of Wisconsin Medical School. The McArdle Memorial Laboratory, of which Dr. Harold Rusch is director, is one of eight similar institutions in the country devoting full time study and research to the problems of cancer.

Drs. Ira R. Sisk and *J. B. Wear* addressed the December meeting of the Society, discussing cancer of the prostate and kidney disease. Doctor Sisk is professor of urology and Doctor Wear is associate professor of urology at the University of Wisconsin Medical School.

THIRD DISTRICT NEWS

C. A. Harper Honored at Testimonial Dinner

America's oldest public health officer, *Dr. Cornelius A. Harper*, was honored at a testimonial program and dinner in Madison, January 31—the date of his official retirement from thirty-nine years of service as Wisconsin's public health officer.

More than 350 persons, representing a cross section of the medical, nursing, and public health profession of the state, came out to pay tribute to "the man who has done more for the advancement of public health in Wisconsin than any other." Speakers at the program included Harry S. Mustard, M. D., health commissioner of New York City; Thurman B. Rice, M. D., Indiana University School of Medicine; Floyd C. Beelman, M. D., state health officer of Kansas, and *Dr. William D. Stovall*, director of the state laboratory of hygiene.

Pointing out that Wisconsin has one of the lowest death rates and very nearly the highest average age, Doctor Harper said that "investments in public health on the part of the state give a larger return than in any other field of activity."

Appointed to the State Board of Health by former Governor LaFollette in 1902, Doctor Harper was reappointed by five governors. Under his guidance the state health department grew from a staff of a single stenographer to a force of nearly 400, and in 1939 he saw Wisconsin reach the rank of third healthiest state in the nation.

R. T. Cooksey Reelected Chief of Staff of Madison Hospital

At the annual meeting of the staff of Madison General Hospital, *Dr. R. T. Cooksey* was reelected chief of staff for 1948. Other officers reelected were *Drs. H. L. Greene*, first vice-president and chief of the surgical department; *T. W. Tormey, Jr.*, secretary and treasurer; *Carl S. Harper*, chief of the obstetric division; and *Mark Foster*, chief of the medical department.

W. J. Urben Begins Duties as Superintendent of Mendota State Hospital

Dr. Walter J. Urben assumed the duties of superintendent of Mendota State Hospital on February 1, succeeding *Dr. M. K. Green*, who retired on January 31 along with *Dr. August Sauthoff*, chief of staff. Both were automatically retired, having reached the age of 70, following more than forty years of service at the state institution. Doctor Urben has been director of the division of mental hygiene in the State Department of Public Welfare.

L. H. Fauerbach Appointed Acting Health Commissioner

Dr. L. H. Fauerbach, assistant health commissioner, has been named acting health commissioner of Madison pending selection of a permanent suc-

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"The Park Hotel Building", Madison 3, Wis.

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cessor of *Dr. Marshall W. Meyer*, who died January 22. *Dr. James M. Wilkie* has been appointed acting assistant city health commissioner.

F. W. Van Kirk Jr. Joins Father in Practice

Dr. Frank W. Van Kirk, Jr., who for the past two years has been associated with the University of Wisconsin, has now joined in medical practice with his father, *Dr. Frank W. Van Kirk*, in Janesville. Doctor Van Kirk, Jr., completed a one year residency at the State of Wisconsin General Hospital and served for one year as an instructor in medicine at the University of Wisconsin Medical School.

E. S. Gordon Addresses Laboratory Staff

At a seminar held in Philadelphia in December, *Dr. Edgar S. Gordon*, Madison, addressed the combined medical and chemical staffs of the Smith, Kline and French Laboratories, located in that city. The subject of his lecture was "Tracer Research and Facilities for Tracer Research at the University of Wisconsin Medical School with More Particular Reference to the Use of Radioactive Iodine for Tracer Research in Thyroid Diseases."

Jackson Foundation Organized to Study Disease

Incorporation papers were recently filed for the Jackson Foundation, Madison, a nonprofit organization to conduct research in the prevention, cause, and cure of disease. The foundation, sponsored by the Jackson Clinic, will also assist selected postgraduate medical students interested in medical research and will provide treatment for indigent patients selected for study of their conditions. Incorporators include *James A. Jackson, M. D., Arnold S. Jackson, M. D., George Ewell, M. D.*, Mr H. R. Heberlein, Harry Steenbock, Ph. D., Ora Rice, D. D. S., and Mr. San W. Orr.

T. J. Snodgrass Presents Results of Survey at Medical Meeting

Results of a survey of the hernia cases in Rock County over a period of years were presented before the Western Surgical Society in Colorado Springs, Colorado, early in December by *Dr. Thomas J. Snodgrass* of Janesville. *Drs. Thomas Flarity*, Beloit, and *W. A. Munn*, Janesville, also attended the meeting as co-authors of the paper.

The survey, covering 1,120 cases, was one of a series which have been made in several fields in Rock County recently.

SOCIETY PROCEEDINGS

Milwaukee

L. J. VAN HECKE

Dr. L. J. Van Hecke was named president-elect of the Medical Society of Milwaukee County at its December meeting. Doctor Van Hecke is assistant professor of pathology at Marquette University School of Medicine.

Milwaukee Neuro-Psychiatric Society

The University Club in Milwaukee was the meeting place of the Milwaukee Neuro-Psychiatric Society on January 21. Papers were presented by *Drs. George E. Moore*, James Hurley, Edward C. Schmidt, *C. Raymond Headlee*, and *R. H. Quade*.

Milwaukee Oto-Ophthalmic Society

Speakers at the January meeting of the Milwaukee Oto-Ophthalmic Society, held January 27 at the Milwaukee Athletic Club, were *Drs. H. G. Schmidt*, Milwaukee, and Walter Hoffman, Iowa City, Iowa. Doctor Schmidt presented a paper entitled "Surgery of Ectopia Lentis Occurring with Arachnodactyly," giving reports of cases with results of lens extraction. He demonstrated his talk with moving pictures. Doctor Hoffman spoke on "Septal Reconstruction as Related to Nasal Physiology," and illustrated his talk with lantern slides and movies. He is from the department of otolaryngology and oral surgery of the University of Iowa Hospitals.

Milwaukee Academy of Medicine

Dr. Elwood W. Mason was installed as president of the Milwaukee Academy of Medicine at the annual dinner meeting held on January 20 at the University Club in Milwaukee. *Dr. Harry Beckman*, professor of pharmacology at Marquette University School of Medicine, was chosen president-elect. Other officers for the coming year are as follows: vice-president, *Dr. William M. Jermain;* secretary, *Dr. Arthur A. Schaefer;* and librarian, *Dr. Maurice*

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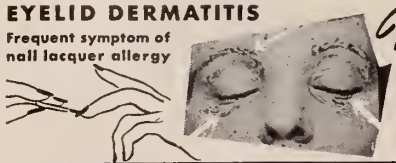
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Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934

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Hardgrove. A paper "Doctors as Statesmen and Politicians" was presented by Dr. E. H. Ackerknecht, professor of medical history at the University of Wisconsin Medical School.

At the December meeting of the Academy, also held at the University Club, Dr. Ralph Ghormley, clinical professor of orthopedic surgery at the University of Minnesota Medical School spoke on "Shoulder and Arm Pain: Diagnosis and Treatment."

TWELFTH DISTRICT NEWS

Clara B. Hipke Memorial Library to be Established

A library on obstetrics and gynecology will be established at the Marquette University School of Medicine in honor of the late Mrs. Clara B. Hipke, former president of the Maternity Hospital and Dispensary Association. Mrs. Hipke died in 1938. An initial donation of $16,500 has been given by the association, which was founded by Mrs. Hipke in 1906 and now is being liquidated. Several thousand dollars more will be contributed by the association when it completes this dissolution. The library is to be known as the Clara B. Hipke memorial and will be part of the general library of the medical school. Books on obstetrics and gynecology now in the school library will form a nucleus.

E. J. Senn Wills Money For Construction of Milwaukee Hospital

Dr. Emanuel J. Senn, who died December 14 in Chicago, left a provision of $300,000 in his will for the construction and maintenance of a Milwaukee hospital, to be known as the Nicholas Senn Hospital, commemorating his father, the late Dr. Nicholas Senn. Selection of the hospital site and handling of the funds will be in charge of the board of directors of Milwaukee Hospital. Dr. Nicholas Senn practiced in Milwaukee until 1891, and served as chief of staff of Milwaukee Hospital, then known as Passavant Hospital. He left in 1891 to become professor of surgery at Rush Medical College in Chicago.

C. H. Kalb Addresses Hospital Staff

Dr. Clifford H. Kalb addressed the staff of the Evangelical Deaconess Hospital of Milwaukee at their November meeting. He spoke on "Reactions to Antibiotics" and also on "Asthma Due to Food Allergy."

SOCIETY RECORDS

New Members

Robert K. Salter, Cadott.

John P. Walker, Mondovi.

O. Mark Schneider, Blair.

James C. McCullough, 20 Forest Avenue, Fond du Lac.

Albert G. Martin, 231 West Michigan Avenue, Milwaukee 3.

George E. Moore, 135 West Wells Street, Milwaukee 3.

Robert E. Flood, 615 North Water Street, Sparta.

James L. Dean, 114 North Carroll Street, Madison.

Harold N. Lubing, 1300 University Avenue, Madison.

Donald G. Dieter, 1300 University Avenue, Madison.

Edwin C. Albright, 1300 University Avenue, Madison.

Jules Chase, Veterans Administration, Wood.

Henry R. Alpert, 4418 North Woodruff Street, Milwaukee 11.

Joseph M. Lubitz, Veterans Administration, Wood.

Robert E. Hayes, 1227A Elm Lawn, Wauwatosa 13.

Robert J. Schiffler, Milwaukee County General Hospital, Wauwatosa 13.

Clarence A. Rothe, Jr., 113 South Quincy Street, Green Bay.

Frank J. Scheible, 632 High Street, Racine.

James M. Foerster, 1024 Steuben Street, Wausau.

William P. Young, 1300 University Avenue, Madison.

George B. Corcoran, Jr., 1300 University Avenue, Madison.

Donald M. Bailey, Gillett.

Howard A. Winkler, Pardeeville.

Changes in Address

P. O. Triggs, Thorp, to Bloomer.

W. H. Miller, Jr., Racine, to 1503 East Mulberry Street, Goldsboro, North Carolina.

R. C. Richardson, Saulte Ste. Marie, Michigan, to Corwin Hospital, Pueblo, Colorado.

H. Phillip Dohn, Milwaukee, to 525 Seventh Street, Eureka, California.

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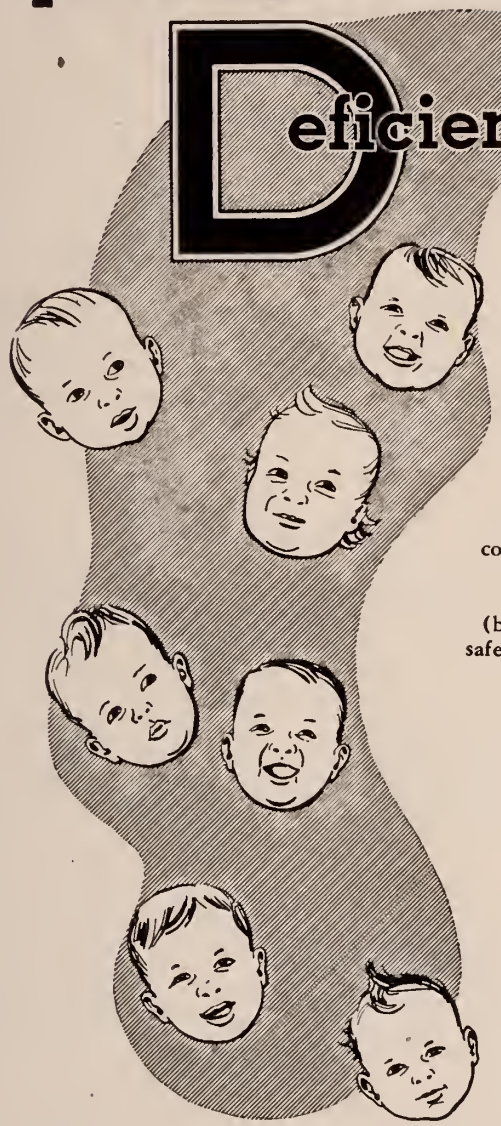
"protein Deficiency [in children] is much more common than is generally realized."*



Investigators have shown that when the variety of foods is limited – as in infant feeding – care must be exercised in their selection . . . the chief consideration being "the furnishing of the essential amino acids to be made available to the tissues by digestion."*

DRYCO, spray-dried for ready reconstitution in cold or warm water, provides the physician with a remarkably flexible basic high protein food, containing all the essential amino acids. It is ideally suited to the changing nutritional requirements of the normal or abnormal infant. Easily digestible (because of its soft curd characteristics), bacteriologically safe and constant in composition – this vitamin-fortified, improved, infant food may be readily adapted to six distinct types of formulas:

1. DRYCO alone *(high protein, low fat, low carbohydrate).*
2. DRYCO with carbohydrate *(high protein, low fat, high carbohydrate).*
3. DRYCO with whole milk – fresh, evaporated or dried *(high protein, intermediate fat, low carbohydrate).*
4. DRYCO with whole milk–fresh, evaporated or dried–and carbohydrate *(high protein, intermediate fat, high carbohydrate).*
5. DRYCO with skim milk – fresh or dried *(high protein, exceptionally low fat, low carbohydrate).*
6. DRYCO with skim milk – fresh or dried – and carbohydrate *(high protein, exceptionally low fat, high carbohydrate).*

*A.M.A.: *Handbook of Nutrition, Chicago, 1943.*

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DRYCO is made from spray-dried, pasteurized, superior quality whole milk and skim milk, providing 2500 U.S.P. units of vitamin A and 400 U.S.P. units of vitamin D per reconstituted quart. Each tablespoon supplies 31½ calories. Dryco is available at all pharmacies in 1 and 2½ lb. cans.

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For simple diagnosis of...

URINE-SUGAR

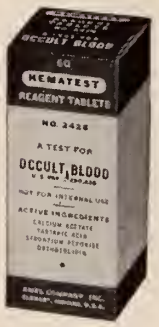
CLINITEST

TABLET NO-HEATING METHOD

SIMPLE AND SPEEDY

Drop one Clinitest Tablet in indicated amount of diluted urine—watch for reaction—compare with color scale.

OCCULT BLOOD



HEMATEST

TABLET METHOD

SIMPLE TECHNIC

Place one drop of specimen solution or suspension on filter paper. Set Hematest Tablet in center of moist area and allow 2 drops water to trickle down from top of tablet to paper. Color reaction on paper denotes presence of blood.

Full information on request.

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George Thorngate, III, Alfred, New York, to 895 Rue Ratard, Shanghai, China.

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R. F. Swanson, Racine, to Oxford.

William Merkow, Fort Eustis, Virginia, to 2503 North Forty-eighth Street, Milwaukee.

L. J. Tauber, Milwaukee, to 72 Eugenia Drive, Ventura, California.

Salvatore Megna, Milwaukee, to 727 North Seventh Avenue, Tucson, Arizona.

F. W. Van Kirk, Jr., Madison, to 322 Hayes Block, Janesville.

G. E. Collentine, Jr., Milwaukee, to 432 South Sixty-second Street, Philadelphia 43, Pennsylvania.

Landers Finseth, Marshalltown, Delaware, to 525 East Michigan Street, Milwaukee.

O. F. Foseid, Neenah, to 216½ Main Street, Menasha.

C. H. Burnett, Milwaukee, to Route 1, Eagle River.

R. B. Larsen, Madison, to 510½ Third Street, Wausau.

C. P. Wangeman, Tacoma, Washington, to 907 East Columbia Street, Seattle 22, Washington.

MARRIAGES

Mrs. Charles J. Allen, Merrill, and Dr. C. S. Rife, Milwaukee, on January 1.

Marie M. Suder, Miami, Florida, and Dr. Fred S. Selle, Milwaukee, on December 30.

BIRTHS

Twin sons to Dr. and Mrs. William E. Gilmore, Madison, January 12.

The following announcement, "Private Industry Triumphs Again," was received in the *Journal* office early in January:

Ceci and Ceci

Designers of Small Models

Tired of government bungling and inefficiency, the firm of Ceci and Ceci, designers of small models, which had gone into retirement for the past five years, emerged into the limelight again with their new model.

At a private and very exclusive showing held at St. Anthony's Hospital on December 28 at 4:50 A.M. their new project, which had been under careful construction for the past nine months, was unveiled.

The co-designers, Gabriel Eugene Sr., and Mary Ceci, remained modestly in the background while their able and efficient Architect-Engineer, Dr. Michael J. Kuhn, officiated triumphantly before the small but select audience. This is the same Dr. Kuhn who so brilliantly executed and delivered the plans for the Junior Ceci model shown five years previously.

Except for some minor alterations the new model remains basically the same as the Junior one. It boasts of a fuzzy thatched roof, darkish red to brown in color, and two lovely picture windows which give out on an expanse of blue. A novel feature has been embodied in the plumbing which is most apt to turn on automatically with no effort on the part of the onlooker.

The overall dimensions of this model are 19¾ inches; 6 pounds 6 ounces. Despite the apparent small size, the designers aver that the interior capacity of their model is more than adequate for all present and future needs.

The public is invited to inspect this model at 5346 North Diversey Boulevard, on Sunday, January 25 from 3 to 5 P.M. At the official christening, earlier the same day, the model will be named Mary Antoinette Ceci.

Plans for future production will be held up because of the heavy schedule now before the Designers and Architect.

DEATHS

Dr. W. H. Remer, 70, physician at Chaseburg for thirty years, died at his home in La Crosse on December 21 after a long illness. The doctor had been forced to retire in 1941 because of ill health.

Born in Big Flats, New York, on June 17, 1877, the doctor came to Wisconsin with his parents when he was a child. He received his medical degree from the Chicago Homeopathic Medical College in 1904, and for the following seven years practiced at Park Falls. From that time until his retirement he had practiced in Chaseburg. During World War I he served with the Army Medical Corps.

Doctor Remer was formerly president of the Vernon County Medical Society and the Tri-County Medical Society comprising Monroe, Juneau, and Vernon counties. An honorary member of the State Medical Society, he was also a member of the American Medical Association.

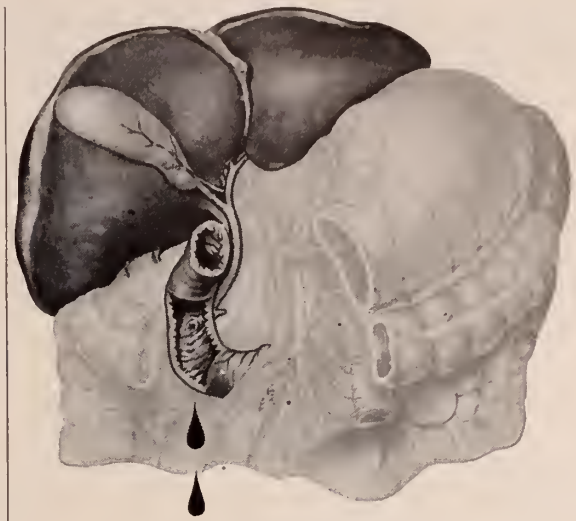
He is survived by his wife, and a niece who had lived at his home since childhood.

Dr. William T. Stafford, a Madison physician, died at a hospital in Madison on December 16 at the age of 34. The doctor had been in practice in Madison for the past three and one-half years.

Doctor Stafford was born on December 17, 1913 in Chippewa Falls. In 1937 he graduated from George Washington University, and in 1942 he received his degree in medicine from the University of Wisconsin Medical School. After an internship at Kansas City General Hospital, Kansas City, Missouri, the doctor spent a year as graduate assistant in pathology at the University of Wisconsin Medical School. Since that time he had been in practice in Madison.

A member of the staff of Madison General Hospital, the doctor also belonged to the Dane County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, a son, and a daughter.



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In discussing the management of chronic cholecystitis without stones, Albrecht states:

"The object of the medical procedure is to assist in draining an infected organ."*

The specific hydrocholeretic action of Decholin (chemically pure dehydrocholic acid) accomplishes this purpose.

Decholin induces bile secretion which is thin and copious, flushing the passages from the liver to the sphincter of Oddi, and carrying away infectious and other accumulated material.

How Supplied: Decholin in 3¾ gr. tablets. Packages of 25, 100, 500 and 1000.

*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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BRAND · REG. U. S. PAT. OFF.

AMES COMPANY, INC.
ELKHART, INDIANA

Dr. M. A. Froney, a practicing physician in Sheboygan for more than a quarter of a century, died at his home in that city on November 25. He was 72 years old.

Born in Carlton on May 11, 1875, the doctor graduated from Milwaukee Medical College, now Marquette University School of Medicine, in 1904. Later that year he established his practice in Sheboygan, where he remained until his death, except for a period of ten years spent as a practitioner in Racine. The doctor served in the Army Medical Corps during World War I.

His wife and two daughters survive.

Dr. C. U. Senn, physician at Ripon for thirty-eight years, died at a Ripon hospital on November 28 at the age of 69.

A native of Campbellsport, Doctor Senn was born on December 15, 1877. After taking premedical studies at Morningside College in Sioux City, Iowa, he entered the Wisconsin College of Physicians and Surgeons, from which he graduated in 1906. He established his first practice in Adell, (Sheboygan City), moving to Ripon several years later. Ill health forced the doctor to retire in 1945.

During World War I Doctor Senn served as captain in the medical corps, and during World War II he was examining physician for the Selective Service System. He was instrumental in the founding of the Ripon Municipal Hospital and for some time served as chief of staff of that institution.

Doctor Seen was a member of the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife and a daughter.

H. J. GRAMLING

Dr. Henry J. Gramling, former president of the Medical Society of Milwaukee County and a well known Wisconsin physician, was killed in an automobile accident near Waukesha on December 10. Doctor Gramling, who was 73 years old, had served nearly eight years on the State Board of Medical Examiners, his last term having expired in 1939. Until recently he had also been chairman of the Committee on Rural Health and Accident Prevention of the State Medical Society.

A native of Dousman, the doctor was born in 1874. In 1899 he received his medical degree from the St. Louis College of Physicians and Surgeons, and shortly afterward he opened a practice at St. Martins. He remained there until 1903, when he went to Europe to take postgraduate studies at Vienna, Austria. He returned to establish a practice in Milwaukee and had remained there since.

For many years Doctor Gramling was a member of the department of surgery at Marquette University School of Medicine, and he served as a director of the Marquette University Hospital until that institution was closed. In addition to serving as president of the organization, the doctor was also director of the Medical Society of Milwaukee County for eight years. Chief of staff of St. Luke's Hospital in Milwaukee, he was for many years chief of the surgical department of that institution.

Doctor Gramling was at one time speaker of the House of Delegates of the State Medical Society and for many years served as a delegate to the Society from the Medical Society of Milwaukee County. In addition to his membership in the county and state medical societies, he was also a member of the American Medical Association.

Doctor Gramling is survived by his widow, Frances M. Gramling, three sons, Gregory, Henry, and William, and one daughter, Mrs. Donald Hughson, the former Dr. Frances Gramling, who prior to her marriage was associated with her father in the practice of medicine in Milwaukee. He was predeceased by two sons, Robert and Captain Anthony J. Gramling, graduate of the Marquette University School of Medicine, who was killed in Italy on January 10, 1944, and who was the first member of the Medical Society of Milwaukee County to be killed in action.

Dr. G. J. Egan, retired La Crosse practitioner, died December 6 in a La Crosse hospital following a long illness. The doctor, who was 70 years old, had retired from active practice in 1933.

Born in Beloit in 1877, Doctor Egan received his degree in medicine from Rush Medical College, Chicago, in 1901. He came to La Crosse following graduation, where he practi ed until his retirement. For a number of years he was La Crosse County physician and was on the staff of St. Francis hospital.

He was a member of the La Crosse County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by two sons and three daughters.

Dr. T. L. Harrington, a physician associated with the Wisconsin Anti-Tuberculosis Association since its organization, died at his home in Milwaukee on December 13, at the age of 81. Doctor Harrington had been a leader in the founding of the Association, and, although he had retired from active practice in 1941, he continued to serve it as staff consultant. From 1912 to 1918 he was a member of the board of directors and executive committee, and for the following two years he served as president. For many years he traveled with the clinic crews throughout the state, and in 1939 he became a member of the senior council.

Pharmaceutical News for Physicians

Every three months the Wisconsin Pharmaceutical Association will present two pages in The Wisconsin Medical Journal of Pharmaceutical news which will be of interest to Wisconsin physicians

AMINO ACIDS — These new products—new in the sense that their importance in the whole picture of medical treatment is becoming more fully recognized—are rapidly taking their place beside vitamins and hormones.

Some of the indications for the amino acids are as follows:

Provides building material for antibody production in bacterial infections in which protein intake is restricted.

Maintains nitrogen equilibrium during periods of nitrogen loss due to diarrhea.

Provides acid binding substances for patients with peptic ulcers or gastric hyperacidity.

Supplies protein needed for blood and serum regeneration in treatment of hypoproteinemia incident to anemia.

Replaces nitrogen losses due to severe burns.

Reduces operative shock and speeds recovery.

Provides readily assimilable nitrogen for patients with liver and kidney diseases.

Increases nitrogen intake of aged and convalescent patients.

DIETHYLSTILBESTROL, U.S.P., 25 mg., Tablets— High dosage tablet, for use in maintaining estrogen levels in pregnancy complicated by diabetes, not to be employed in the treatment of menopausal symptoms. Contraindicated in patients with decreased hepatic function, aplastic anemia, leucopenia, thrombocytopenic purpura, severe kidney damage or pituitary insufficiency.

RUTIN IN POT. THIOCYANATE THERAPY — Rutin restores increased capillary fragility to normal. This also held true in the case of a patient being treated with potassium thiocyanate. Potassium thiocyanate is used in the treatment of hypertensive arteriosclerotic heart disease but often causes an increased capillary fragility and thus is dangerous to use. Zfass, writing in *Virginia Med. Month.* (74:56(Feb. 1947)) feels that the thiocyanate can be used indefinitely once the capillary fragility is returned to normal with rutin. The usual dose of rutin was 20 mg. orally three times a day.

DO YOU RECALL? —(a) Methyl morphine is codeine; (b) Ethyl morphine is dionin; (c) Diacetyl morphine is herion.

TREATMENT OF ENURESIS — Bed wetting, uncontrolable voiding of the bladder, has many causes and forms. Apart from poor infancy training glandular disorders (such as thyroid underactivity), nervousness, excessive drinking of fluids, presence of pinworm, and other infections have been known to cause bed wetting.

However, Dr. I. N. Kugelmass, New York pediatrician, treated 75 children who suffered from this ailment with the male sex hormone (methyl testosterone by mouth or testosterone propionate by intramuscular injection). He has reported in the N. Y. State Journal of Medicine that 59 out of the 75 children were cured; 10 were improved, and 6 failed to respond at all.

PRICE DECLINES — In the face of rising costs, prices of estrogenic and androgenic substances, as well as testrosterone propionates, have been reduced as much as 25%. This should enable the physician to extend hormone therapy to those patients who in the past have been denied treatment because of prohibitive costs.

UNDECYLENIC & PROPIONIC ACIDS IN THE PREVENTION AND TREATMENT OF DERMATOPHYTOSIS — By using paired comparisons and extensive clinical trial the relative efficacy of a number of agents in the prevention and treatment of fungous infections of the feet was established. The prophylactic use of undecylenate-undecylenic acid powder reduced the incidence of dermatophytosis about 85%. Next to this powder the following agents are named in approximate descending order of importance: 5% Diodoquin, 1-3% Vioform in talc, calcium-zinc propionate powder, sodium propionate powder, U. S. Navy foot powder, Boric acid-salicylic acid powder, talcum powder, 5% thiourea in talc. There was no significant difference between undecylenate powder and the ointment.—Marion B. Sulzberger and Abram Hanof. Arch. Dermatol. Syphilol., 55, 391-95(1947).

VITAMIN B1 — The author studied a series of cardiac patients who showed no evidence of avitaminosis but were nevertheless improved symptomatically by the administration of vitamin B1. A dose of 2 mg. of vitamin B1 was given to each patient. It was found that 16% to 29% of the absorbed dose was excreted in the urine. This observation is regarded as further evidence that the improvement brought about by vitamin B1 administration in cardiac patients is not contingent on the existence of avitaminosis. —M. Wybauw, Acta Cardiologica, 1, 18(1946); through Am. Heart J., 33, 544(1947).

QUININE CONTROLS RELEASED — All remaining Government controls over the distribution of quinine were dropped in an amendment of Conservation Order M-121, announced by the Office of Materials Distribution. All quinine, including that purchased under OMD authorization before December 30, 1947, effective date of the amendment, now may be delivered, accepted and used without restriction.

Officials said supplies of quinine, on hand and promised by the Netherlands Government, appear to be adequate for all purposes, and that revocation of controls over their distribution is, in these circumstances, in line with statements by Secretary W. Averell Harriman in his first quarterly report to the President and Congress, under the Second Decontrol Act of 1947.

The changes in M-131 do not affect distribution and use restrictions over cinchona bark and quinidine originating from Government-owned stocks. These remain in full force, to assure availability of the limited supply of quinidine for treatment of cardiac disorders.

ENDOCRINE THERAPY OF CARCINOMA OF THE PROSTATE — The action of the endocrines in prostatic cancer is not fully understood but it seems apparent that the actively growing malignant cells require androgen for their vitality, and when they are deprived of it these cells undergo regressive histological and chemical changes. Orchiectomy eliminates androgens and the administration of diethylstilbestrol seems to neutralize them, possibly by interference with the enzyme balance of the cells. Writing in J.A.M.A. (134:848(July 5, 1947)), Colston and Brendler stated that 75 per cent of the cases treated with diethylstilbestrol showed regression of the primary growth and about 45 per cent regression of metastases, although none have shown complete cure with diethylstilbestrol alone. However, the authors suggested that endocrine therapy (1 to 2 mg. per day) be instituted in all cases of carcinoma of the prostate in order to cause regression of the growth before radical prostatecomy. Many cases otherwise too far advanced for radical surgery will regress sufficiently to make surgery possible and successful in a large percentage of the cases.

SAFE PARENTERAL BACITRACIN MADE—Bacitracin has now been brought to the stage where it can be safely administered parenterally, it was disclosed here before the American Association for the Advancement of Science.

This antibiotic has previously been used successfully in localized infections. It was not sufficiently uniform and free from toxic elements to enable parenteral administration. However, advances in manufacturing during the past year have steadily improved the product, so that it can now be given in effective doses systemically for infections which have spread beyond the local area.

Drs. Meleney and Johnson, in their report given before the A.A.A.S., referred to their earlier work (J.A.M.A., 133: 675, 1947), covering almost 200 cases of the use of bacitracin in surgical infections.

They also referred to some unpublished studies covering the use of bacitracin in over 150 cases of dermatological disorders.

Drs. Meleney and Johnson stated "we believe that we have clearly demonstrated in all of these three groups that bacitracin is a potent antibacterial agent which will inhibit or stop the activity of many different common infective agents and the bacterial mixtures which are commonly found in these conditions."

ESTROGEN CREAM ELICITS NO SYSTEMIC EFFECTS — No systemic effect was produced by an estrogen cream applied daily for 11 to 16 weeks to the skin of the face by 14 women, reports Dr. Joseph Eidelsberg, chief of the Endocrine Clinic, New York Post Graduate Medical School and Hospital, Columbia University. His conclusion is based upon studies of the excreted estrogens during the period when the cream was applied, as compared with the excretion during a control period when the cream was not used. It is also based upon vaginal smear studies.

The ages of the subjects were as follows: (1) 18 years, (2) 22 years, (3) 23 years, (4) 30 years, (5) 34 years, (6) 35 years, (7) 39 years, (8) 42 years, (9) 44 years, (10) 44 years, (11) 44 years, (12) 46 years, (13) 51 years, and (14) 56 years.

Patient No. 13 had begun to have menopausal symptoms, although still menstruating irregularly, and patient No. 14 had ceased to menstruate 5 years before. In addition to the test groups, there were four women who were used as non-treated controls.

The variations in estrogen output during the period of use of the estrogen cream by the 14 women were not significantly different from those in the same women during the pre-inunction period, or from those in the untreated controls, Dr. Eidelsberg concludes in *Am. J. Med. Sciences*, Dec., 1947, page 630.

AMINOPHYLLINE FOR MENTAL DISEASES — The drug Aminophylline (Theophylline double salt), well known for its use as a heart stimulant and for the relief of coronary pain, has been used by Drs. Hans H. Reese and Fritz Kant, of the Neuropsychiatric Department of the University of Wisconsin Medical School, Madison, for the treatment of mental symptoms—loss of memory, confusion, hallucination, and so forth. These brain symptoms, however, were associated with high blood pressure and (or) arteriosclerosis of the brain. The brain was receiving less blood than it needed, hence the symptoms. The drug dilated the blood vessels and relieved the mental symptoms in 23 out of 32 cases.

NEW ISOMER OF METHADON MAY SIDESTEP ADDICTION — An isomer of methadon has been found which is but slightly weaker in analgesic effect but may be less likely to lead to addiction. It also shows fewer side reactions and less euphoric action. This was revealed before the American Pharmaceutical Manufacturers Association, which met in New York City last month, by Dr. Nathan B. Eddy, secretary of the Committee on Drug Addiction and Narcotics, Division of Medical Sciences, National Research Council.

Speaking in "Progress in Drug Therapy of Pain," Dr. Eddy also reported recent data on metopon, which confirmed its advantages over morphine to relieve pain in the terminal stages of cancer. Metopon has been found far less likely to bring about nausea, according to figures which he presented.

Of 1270 cases of cancer where metopon has been used, control of pain was rated as "complete" in 488, and as "fair" in 574. The two classifications aggregate 80% of the cases. No side reactions were observed in 90% and the mental condition of the patients remained clear in 74%.

REPLACED MORPHINE — More striking still, according to the speaker, were the results with 284 for whom this drug was used because morphine and related substances had proved to be too distressing.

Dr. Eddy noted that the fact that metopon can be administered by mouth is also an advantage; moreover, tolerance and addiction develop slowly, he stated.

TOPICAL USE OF SULFAS & ANTIBIOTICS — Local, rather than systemic, use of sulfonamides and antibiotics is strongly criticized by Dr. Perrin H. Long of the Department of Preventive Medicine, Johns Hopkins University.

"Nothing appears to be gained from treating a minor infection locally (when parenteral or oral therapy will achieve the same end) if the patient becomes sensitized to the drug, and is thus deprived of its valuable effects in later perhaps more serious infections," states Dr. Long.

In an article in the *New England Journal of Medicine*, 237:837, 1947, he adds, "there is little evidence that the sulfas and antibiotics, when used externally in dusting powders, creams, lotions or salves, give beneficial effects which outweigh the known risk of sensitizing the patient."

Penicillin was originally considered to be relatively nontoxic, Dr. Long remarked. However, adverse reactions have become more frequent with increasing use of antibiotics, he asserts.

AMMONIUM CHLORIDE —The Absorption of Enteric Coated. The author reports the not infrequent failure of enteric-coated tablets of ammonium chloride to be absorbed from the gastrointestinal tract. These may be observed as opaque particles by X-ray. In many instances in healthy young adults, prolonged administration of such tablets resulted in no acidosis, although the tablets were destroyed before excretion, presumably at a level too low in the gastrointestinal tract to allow absorption. The author feels that the absorption of enteric-coated tablets is at best unpredictable. He later used ammonium chloride heavily coated with gelatin and observed gastric discomfort in only 2 of 60 cases; absorption occurred in all cases.—F. L. Selye. Can. Med. Assoc. J., 55, 45(1946); through Am. Heart J., 33, 545(1947).

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MILWAUKEE, WISCONSIN

Born at Bear Creek on September 8, 1866, Doctor Harrington received his doctor's degree from the University of Pennsylvania School of Medicine in 1905. Several years later he took postgraduate studies in Europe. His first practice was opened at Antigo, and in 1900 he moved to Milwaukee. From 1937 to 1941 he served as medical director of River Pines Sanatorium at Stevens Point. During World War I the doctor served as a major in the Army Medical Corps.

Doctor Harrington was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Doctor Harrington was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors are his wife, a daughter, and two sons, one of whom is Dr. Earl T. Harrington of Milwaukee.

Dr. C. S. Wasweyler, who had practiced medicine in Milwaukee for forty-two years, died at a Milwaukee hospital on November 24. The doctor was 78 years old.

A native of Milwaukee, Doctor Wasweyler was born on April 22, 1869. He spent several years at Marquette University School of Medicine and received his degree in medicine at the University of Wisconsin. He then took a postgraduate course at Rush Medical College in Chicago, following which he established the practice in Milwaukee which he continued until his death. The doctor is survived by his wife.

Dr. Urban J. Durner, 57, a Milwaukee eye, ear, nose, and throat specialist died suddenly at a Milwaukee hospital, after a two week illness, on December 3. The doctor was a resident of Thiensville.

Doctor Durner was born in Milwaukee on May 19, 1890. He graduated from Marquette University School of Medicine in 1913. In September 1914 he went to Europe to specialize, serving as home surgeon at the Central London Throat and Ear Hospital and the Royal Ophthalmic Hospital. He returned to the United States late in 1916 and became a protege of the late Dr. Joseph Schneider, world famous eye specialist. In 1917 he enlisted in the Army Medical Corps. Following the war, he rejoined Doctor Schneider and served as his assistant until 1925, when Doctor Schneider retired.

He had been on the staff of St. Joseph's Hospital since 1916 and was chief of staff in 1934. For his services with Selective Service during World War II, Doctor Durner was presented wth the Selective Service Medal and the Presidential Certification of Appreciation.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving are his wife and a daughter.

Dr. William H. Banks, 73, former physician at Hudson, died at his home in Yakima, Washington, on December 24.

A native of Windom, Minnesota, Doctor Banks established a practice in St. Croix County in 1900, following his graduation from Keokuk Medical College of Physicians and Surgeons, Keokuk, Iowa. He practiced in Wisconsin and Minnesota until 1921, when he moved to Yakima, Washington.

His wife, a son, and a daughter survive.

M. W. MEYER

Dr. Marshall W. Meyer, 46, health commissioner for the city of Madison, died suddenly in his office on January 22. The doctor had taken over the duties of health commissioner on November 1, succeeding Dr. F. F. Bowman.

Born in Chicago on August 15, 1901, Doctor Meyer lived there until 1930, when he moved to Wisconsin. He received his degree in medicine from Rush Medical College in 1927, serving his internship at Ravenswood Hospital in Chicago. In 1930 he established a practice in Almond, where he also served as village health officer and township health officer.

In 1939 the doctor joined the staff of the State Department of Health as a district health officer, serving in that capacity in the Ashland district and later in the Green Bay area. In 1946 Doctor Meyer accepted a similar position in Florida, but he returned to Wisconsin within the year to take charge of the venereal disease division of the Department of Health. He resigned from this position to take over his duties as Madison's health commissioner.

Doctor Meyer was a fellow in the American Public Health Association and a member of the Dane County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and two daughters.

Dr. J. A. Keithley, who retired from practice in Palmyra in 1929 after serving the health needs of that community for more than a quarter of a century, died at his home in Lakeland, Florida, on January 15. The doctor was 73 years old.

Doctor Keithley was born in Georgetown, Indiana on May 5, 1874. He received his degree in medicine from Illinois Medical College, now Loyola University School of Medicine, in 1902 and began his practice in Palmyra later that year. During World War I he served as a first lieutenant in the Army Medical Corps. Because of his health, the doctor retired in 1929. Since last year he had resided in Florida.

Survivors include his wife and two sons.

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Dr. Edgar M. Wilson, 83, practitioner in Jefferson for seventeen years, died after a brief illness at his home in Jefferson on January 1. The doctor had retired from active practice in 1939.

A native of Bristol, Doctor Wilson was born on March 2, 1864. He graduated from Northwestern University Medical School, and some time later began practice in Lake Geneva. From there he moved to Jefferson in 1922.

Surviving the doctor are a son and a daughter.

Dr. H. F. Fredrick, Sr., physician in Westfield and the surrounding area for more than fifty years, died January 16 at his home in that community. He was 84 years old.

Doctor Fredrick was born on January 9, 1864 in Potters County, Pennsylvania, and as a child moved with his parents to Augusta. In 1887 he graduated from the University of Wisconsin School of Pharmacy, and several years later he secured his degree in medicine from the University of Michigan Medical School. The doctor established his first practice in Friendship, moving to Westfield some years later.

His wife, a daughter, and two sons survive.

THE WOMAN'S AUXILIARY

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Mrs. J. W. MacGregor, Portage

Convention—
Mrs. A. J. Randall, Kenosha

Mid Year Board Meeting

The Second State Conference of the Woman's Auxiliary to the State Medical Society of Wisconsin was held Wednesday, February 4, 1948 at Hotel Schroeder, Milwaukee.

The school of instruction was held at 10:30 o'clock at Hotel Schroeder.

The conference opened with a 1 o'clock luncheon. Dr. William D. Stovall, President of the State Medical Society, spoke on: "Wisconsin Physician's Service."

Nominating Committee Members

Mrs. A. J. McCarey, Green Bay
Mrs. A. H. Barr, Port Washington
Mrs. R. B. Dryer, Poynette
Mrs. W. B. Hildebrand, Neenah
Mrs. C. D. Partridge, Cudahy

Alternates

Mrs. B. J. Brindley, Madison
Mrs. H. J. Heeb, Milwaukee
Mrs. N. A. Hill, Madison
Mrs. P. T. Walters, La Crosse
Mrs. G. D. Reay, Onalaska

Convention Chairman

Mrs. A. W. Hammond has appointed Mrs. A. J. Randall, Kenosha, chairman for the state convention to be held in Milwaukee next fall.

SOCIETY PROCEEDINGS

Dane

The Auxiliary to the Dane County Medical Society met at the home of Mrs. C. A. Harper for a dessert luncheon on December 8. After the business meeting, a program of Christmas music was given under the direction of Mrs. R. M. Heffner.

Fond du Lac

The Auxiliary to the Fond du Lac County Medical Society held its first meeting of the new year at the home of Mrs. L. J. Simon on October 23. There were 32 members present. Mrs. A. W. Hammond was the honored guest and presented an outline of the year's work for the State Auxiliary.

The December meeting of the Auxiliary was held in the home of Mrs. Joseph C. Devine. After the business meeting, Mrs. Glenn Hoffman of Appleton entertained with an interpretation of the play "Years Between."

La Crosse

The Auxiliary to the La Crosse County Medical Society met at the home of Mrs. E. H. Townsend, La Crosse, for its October meeting.

Mrs. George Ridout, president, reported on the state convention, and Mrs. James Fox on the centennial meeting in Atlantic City.

In behalf of the medical profession

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Some things you should know about the common cold

No. 209 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

MOST PEOPLE in the United States and Canada have two or more colds a year, each lasting about two weeks and causing a considerable amount of stuffy discomfort.

The danger of the common cold lies mainly in the other infections that may follow after it. For a cold lessens your resistance, and is likely to pave the way for other, more serious, respiratory ailments.

Sinusitus, ear infections, bronchitis, and the various forms of pneumonia are frequently ushered in by a cold. Pneumonia, particularly, is likely to attack a person who is overtired, or run-down because of a severe cold.

True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection-fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases.)

But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose your ailments. Let him decide what treatment is best for your particular case. Then follow his instructions to the letter. His advice is the only advice you should take on any question that concerns your health.

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Mrs. James Fox, retiring president of the State Auxiliary, was presented with an engraved silver tray in appreciation of her work during the past year.

Milwaukee

On December 12 the Auxiliary to the Medical Society of Milwaukee County met for 12:30 luncheon at the Knickerbocker Hotel.

The president, Mrs. William P. Studley, welcomed seventy-five members and guests.

Christmas hymns and folk songs were presented by the Rufus King High School A Capella Chorus. A short business meeting followed.

Members of the Milwaukee group are greatly honored because Mrs. Eben Carey and Mrs. Robert Fitzgerald have been made honorary members of the Wisconsin State Auxiliary.

Sauk

The October meeting of the Auxiliary to the Sauk County Medical Society was held at the Warren Hotel in Baraboo for a 1 o'clock luncheon. Fifteen members were present.

During the business meeting, several projects were discussed considering a philanthropic project for the Auxiliary. The members were urged to follow with interest the P.T.A. health program broadcast each Saturday morning.

November 11 the Auxiliary met at the home of Mrs. Milton Trautmann in Prairie du Sac. Fourteen members were present.

The next meeting will be held in Reedsburg at the home of Mrs. John Booker.

Walworth

The Auxiliary to the Walworth County Medical Society has given an Ampro film strip and slide projector to the Walworth County Schools. It will be used by county superintendents and supervising teachers to show educational pictures, thus enriching the teaching through the use of visual aids.

The Auxiliary also made it possible for all the rural and state graded schools in the county to receive the health magazine *Hygeia* at half price for one year.

Washington—Ozaukee

The women of the Auxiliary to the Washington–Ozaukee County Medical Society were entertained by their husbands at the Republican Hotel in Kewaskum for the December meeting. Separate business meetings were held following the dinner.

Mrs. C. P. Kauth succeeded Mrs. E. L. Bernhardt to the presidency. In Mrs. Kauth's annual report many activities of the Auxiliary were listed. Included in these activities were thirty-seven gift subscriptions of *Hygeia* to county schools, cash gifts to the Milwaukee Curative Workshop, the American Red Cross, and the Field Army for Cancer Control, Christmas gifts to veterans and an award of twenty-five dollars to LaVerne Schart of Kewaskum for first place in the contest "American Medicine, My Heritage." A study program of medicinal and health problems occupied the meetings of the Auxiliary for the past year.

Winnebago

Reports of the state meetings held in Milwaukee were given during the business session of the Auxiliary to the Winnebago County Medical Society in October. Thirty-five members were present.

The December meeting was held at the Congregational Church at Menasha. Mrs. Robert Brown had prepared a diversion of Christmas carols and an interesting lecture. Mrs. Herbert Speigelberg, Appleton, gave an illustrated lecture on her native land, Bulgaria.

BULLETIN ON INFANTILE PARALYSIS DISTRIBUTED BY THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

A compact instructional bulletin containing abstracts of all the discussions and presentations during the two offerings of the course, "The Diagnosis and Therapy of Poliomyelitis," given at the University of Wisconsin Medical School during the past summer has been sent out to the membership of the State Medical Society. This material as originally presented was in mimeographed form, but due to the number of requests for it, it was reproduced in bulletin form by the University of Wisconsin Medical School and the cost underwritten by the National Foundation for Infantile Paralysis, Inc. through funds raised by the March of Dimes.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

History of Medicine. By Cecilia C. Mettler, A. B., Ed. B., A. M., Ph. D., Late Assistant Professor of Medical History, University of Georgia, School of Medicine, and late Associate in Neurology, College of Physicians and Surgeons, Columbia University. Edited by Fred A. Mettler, A. M., M. D., Ph. D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Pp. 1215, with 16 illustrations. Philadelphia and Toronto: The Blakiston Company, 1947. Price $8.50.

In presenting the history of medicine from its beginning to our own day the author, who died in 1943, does not follow the traditional horizontal subdivision into periods (Pre-history, Egypt, Greece, Middle Ages, etc.). She gives fourteen separate, vertical histories (of anatomy, physiology, pharmacology, pathology, physical diagnosis, medicine, neuropsychiatry, neurology, dermatology, pediatrics, surgery, gynecology and obstetrics, ophthalmology, otology and rhinolaryngology).

The unfortunate result of this arrangement is a maze of technical facts and a text of very low readability, that is not improved by double column printing and a rather indifferent style. It is hard to understand that a professional historian should have chosen a method that is almost bound to destroy historical perspective and to eliminate the cultural and personal background of our subject. It is not surprising that with this method such an essential aspect of the history of medicine as preventive medicine is practically missing in what pretends to be a comprehensive and systematic book. While hundreds of irrelevant names obstruct its 1104 pages, those, for instance, of E. Chadwick and L. Shattuck are absent.

The author's ahistoric attitude is also evidenced by the systematic "debunking" of almost any period or noteworthy personality she is dealing with. She does not limit herself to a perfectly legitimate re-evaluation of the one or the other author or period;

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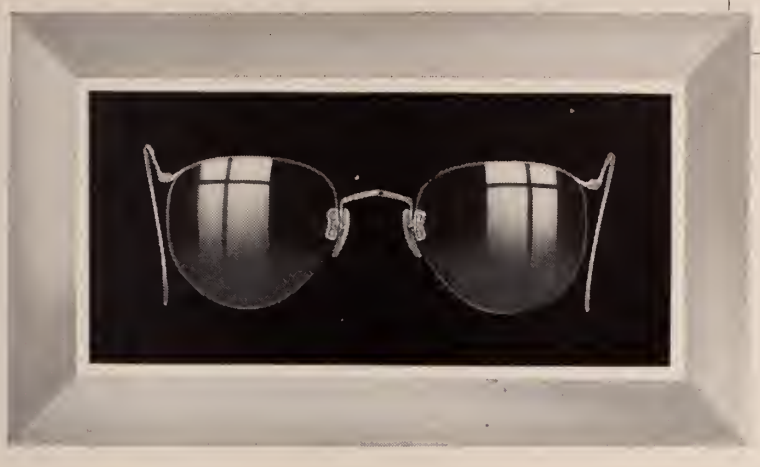

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she just dismisses the whole class, from Hippocrates to Virchow, with bad marks.

It can, under these conditions, not be left unmentioned that the number of the author's own factual errors is not inconsiderable, and her obvious aversion to consult medicohistorical literature written in other than the English and Latin languages, contrasts strangely with her comments on the "provincialism" of other historians.

To use the book as a text for students, as recommended, could have only the most discouraging results. It does not replace F. H. Garrison's admirable "Introduction" as a reference book for the teacher either, having neither its scholarship and judgment, nor its aesthetic and human values.

The book will be of a limited value as a reference book, to be consulted together with sources and other writings, for those interested in the history of a specialty or a specific topic. Some of the shorter chapters like that on pathology or physical diagnosis make stimulating and informative reading.

This reviewer is too well aware of the enormous amount of industry, intelligence, and honest scholarship that have gone into the composition of this book and too little of a debunker, to establish his conclusions with anything but the feelings of deep regret. Yet in almost twenty-five years of book reviewing he has always felt that his duty to the reading public to tell what he thinks to be the truth, does prime any other consideration.—E. H. A.

The Foot and Ankle; Their Injuries, Diseases, Deformities and Disabilities. By Philip Lewin, M. D., F. A. C. S., Associate Professor of Bone and Joint Surgery and Acting Head of Department, Northwestern University Medical School; Professor of Orthopaedic Surgery, Post-Graduate Medical School of Cook County Hospital; Attending Orthopaedic Surgeon, Cook County Hospital; Senior Attending Orthopaedic Surgeon, Michael Reese Hospital, Consulting Orthopaedic Surgeon, Municipal Contagious Disease Hospital, Chicago; Formerly Colonel, Medical Corps, Army of United States. Pp. 847, with 389 illustrations. Philadelphia: Lea & Febiger, 1947. Price $11.00.

This book thoroughly covers all disturbances of the foot and ankle that any practicing physician or orthopedist may encounter. It has a wealth of practical material for the treatment of the common minor disorders of the feet that are of such great magnitude to the patient.

In this third edition there has been added much of the personal experience of the author by acting as consultant for the Army in the last World War. More recent advances in changing concepts regarding the etiology and treatment of foot and ankle disturbances have been included.

Another fact that makes this book of special interest is the foot has not been divorced from the body as a whole, and the effects of systemic diseases as related to the foot and leg are considered. This is important because it is unscientific to consider the foot as a single unit, and on reviewing this book it is at once apparent to the reader that disorders

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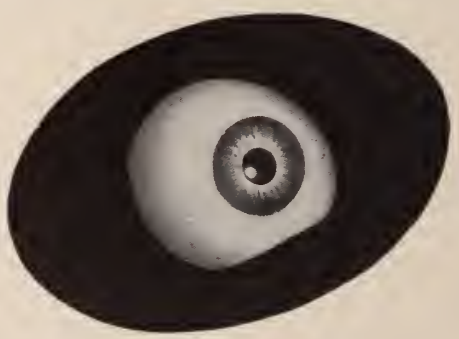

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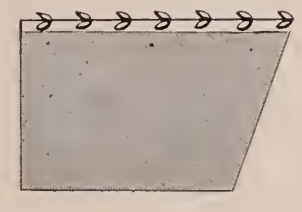

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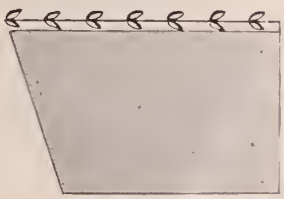

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of the foot and ankle may be intimately associated with nutrition of the body as a whole, functional integrity of the nervous system and circulatory system, and the whole field of medicine. For this reason it is of special interest to the general practitioner and a necessary volume in his library.—H. W. W.

Practical Clinical Psychiatry. By Edward A. Strecker, A. B., A. M., Sc. D., Litt. D., LL. D., M. D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, A. B., M. D., Professor of Psychiatry, University of Colorado, School of Medicine; Director, Colorado Psychopathic Hospital; and Jack R. Ewalt, M. D., Professor of Neuro–Psychiatry; Director, Galveston State Psychopathic Hospital, University of Texas Medical Branch. Section on Psychopathologic Problems of Childhood by Leo Kanner, M. D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine. Sixth Edition. Pp. 476. Philadelphia and Toronto: The Blakiston Company, 1947.

The sixth edition of this widely used textbook of psychiatry is decidedly a further improvement. It gives a very good and critical revew of the entire field of psychiatry clearly presented and well organized. The authors have the courage to to say repeatedly that the answers to important problems in psychiatry have not yet been found. In showing different approaches to the same problem and different possible interpretations of the same facts, they protect the reader from self-contented dogmatic theories which are bound to retard progress.

The book is to be recommended as a text for medical students as well as a source of information for general medical men who increasingly realize the importance of psychosomatic relationships in their daily work.—F. K.

Physical Medicine in General Medicine. By William Bierman, M. D. Attending Physical Therapist, Mount Sinai Hospital; Assistant Clinical Professor of Medicine, Columbia University. With a chapter on Medical Rehabilitation by Dr. Sidney Licht. Second Edition, Revised and Enlarged. Pp. 686, with 310 illustrations. New York and London: Paul B. Hoeber, Inc., 1947. Price: $8.00.

The second edition of this textbook contains an article by Doctor Licht on rehabilitation. The inclusion of a chapter in occupational therapy is advantageous.

The first fifteen chapters discuss the different technics used in physical medicine. The last nine chapters discuss the indication and contradictions of physical procedures in different diseases.

In the action on short wave diathermy considerable attention is paid to cuffs and pads in spite of the many disadvantages of these methods. The description of fever therapy is hardly up to modern standards. In a number of places it is difficult to realize that one is reading a book published in 1947.

On page 431 the author states, "The physician assumes legal responsibility when he treats patients by physical agents just as he does when he employs chemical agents. He must therefore exercise reasonable professional care in the treatment of his patient." Fortunately most physicians, including those who practice physical medicine, give their patients considerably more than "reasonable care" without the threat of legal action.—H. D. B.

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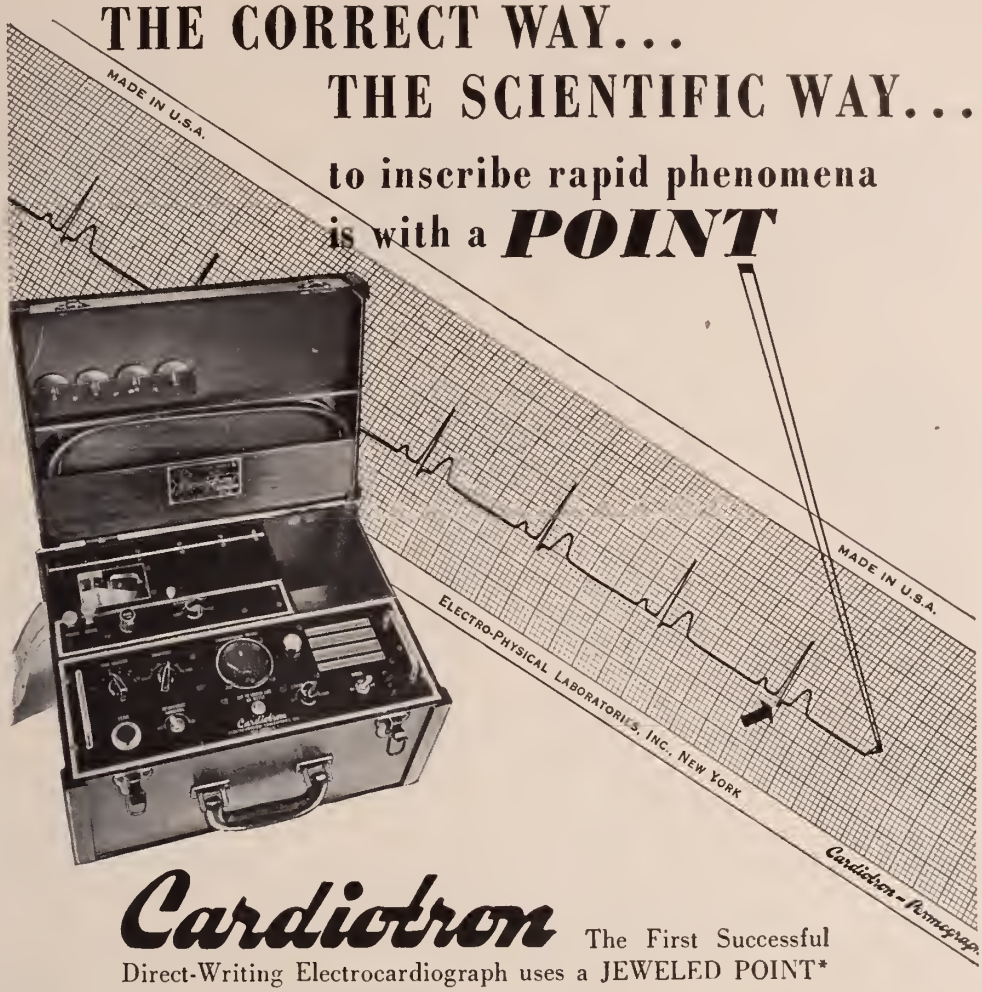

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COMING EVENTS

Orthopedic Field Clinics Scheduled For Wisconsin

The orthopedic field clinics conducted by the Crippled Children Division of the State Bureau for Handicapped Children have been scheduled for the first six months of 1948. The clinics are for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Forms should be requested in advance of the clinic date, in order that adequate personnel may be supplied. Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Clinics have been arranged as follows:

Racine	March 12
Manitowoc	April 2
Green Bay	April 8–9
Sheboygan	April 15–16
Eau Claire	April 22–23
Appleton	April 29–30
Superior	May 7
Kenosha	May 12–13
La Crosse	May 19–20
Chippewa Falls	June 18
Janesville	June 24

Correspondence should be addressed to the Bureau for Handicapped Children, 146 North, Capitol, Madison 2, Wisconsin.

Institute on Cancer at University of Wisconsin

Information has just been released by the University of Wisconsin Medical School that an institute on cancer is being planned at that institution from March 22 through March 25. This institute is being jointly sponsored by the University of Wisconsin Medical School, the Wisconsin Division of the American Cancer Society, the State Board of Health of Wisconsin, and the State Medical Society of Wisconsin, with participation by the State Laboratory of Hygiene and the McArdle Memorial Laboratory for Cancer Research. It promises to be one of the most intensive enterprises of its type to be held in this area of the country. Material to be included covers such subjects as the enzymatic control of cell growth, discussion and demonstration of the Papanicolaou technic, and biopsy study and technics. There will be detailed study and discussion of malignant lesions of the genito-urinary tract, the gastrointestinal tract, and the organs of the female pelvis. X-ray diagnosis, gastroscopy, and bronchogram technic will be demonstrated.

The final day of the institute will include a joint meeting with the Field Army of Wisconsin and will cover such material as the organization of a successful cancer detection center, with a discussion of the newer diagnostic methods.

The meetings will be held at the University of Wisconsin Medical School during the first three days of the institute, and the final day's sessions will be held in the Play Circle of the Wisconsin Memorial Union Building. Further details concerning this undertaking may be obtained from Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin. The program follows:

MONDAY, MARCH 22

9:00–10:00 Registration—Room 103, The State of Wisconsin General Hospital—*Dr. L. R. Cole*

10:00–10:15 Greetings and Announcements—*Dr. Wm. S. Middleton, Dr. H. M. Coon, Dr. L. R. Cole*

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10:15–10:30 Government Participation in Cancer Control —*Dr. C. N. Neupert*
10:30–10:45 The American Cancer Society and Its Significance to The Wisconsin Cancer Control Program—*Mr. Robert O. McLean*
10:45–11:00 The State Medical Society of Wisconsin Cancer Control Program, Past and Present—*Mr. Roy Ragatz*
11:00–11:15 Cancer and Its Reporting as Currently Practiced—*Dr. Van Duser*
11:15–12:00 Inspection Tour of McArdle Memorial Laboratory for Cancer Research—*Dr. Harold P. Rusch*
Noon Recess
1:30– 2:00 The Causes of Cancer—*Elizabeth Miller*
2:00– 2:30 The Mechanism of Cancer Formation—*James Miller*
2:30– 3:00 The Particulate Components of Cells—*Walter Schneider*
3:00– 3:15 Recess
3:15– 3:45 Enzymatic Control of Cell Growth—*Dr. Van R. Potter*
3:45– 4:15 Factors Modifying Tumor Formation—*Dr. Harold Rusch*
4:15– 5:00 Round Table with participation by faculty for afternoon session
5:00 Social Hour
6:30 Dinner

TUESDAY, MARCH 23

9:00– 9:40 Cancer of the Cervix—Early Lesions—Their Manifestations and Differential Diagnosis —*Dr. John W. Harris*
9:40–10:20 Cancer of Corpus Uteri—*Dr. Ralph E. Campbell*
10:20–10:30 Recess
10:30–11:30 Discussion of Papanicolaou technique; Biopsy in Cancer of Cervix and Uterus—*Dr. Wm. D. Stovall*
11:30–12:00 Round-Table Discussion, with participation by faculty of morning session
Noon Recess
1:30– 2:10 Cancer of The Skin—*Dr. Fred E. Mohs*
2:10– 2:30 Biopsies and Necessary Considerations in Obtaining Material for Pathologist—*Dr. Walter Jaeschke*
2:30– 2:40 Recess
2:40– 3:30 Cancer of The Bladder and Prostate—Early Recognition and Therapeutic Measures Available—*Dr. John B. Wear*
3:30– 4:30 (a) One half the group—Demonstration of Papanicolaou technique
(b) One half the group—Laboratory Demonstration of the Cytological Recognition of Malignant Cells in Smears by Papanicolaou Method — *Dr. W. D. Stovall, Dr. L. L. Swan and Miss Norma Freitag*
4:30– 5:30 (b) One half the group—Demonstration of Papanicolaou technique
(a) One half the group—Laboratory Demonstration of the Cytological Recognition of Malignant Cells in Smears by Papanicolaou Method — *Dr. Stovall, Dr. Swan and Miss Freitag*

WEDNESDAY, MARCH 24

9:00 Cancer of the Gastrointestinal Tract
(I) Oesophagus—*Dr. J. W. Gale*
9:25– 9:50 (II) Stomach—*Dr. E. R. Schmidt*
9:50–10:15 (III) Colon and Rectum—*Dr. K. E. Lemmer*
10:15–10:30 Recess
10:30 (IV) X-ray Diagnosis of Malignant Lesions of the Gastrointestinal Tract — *Dr. L. W. Paul*
10:50 (V) Gastroscopy—as a Diagnostic Measure—*Dr. K. L. Puestow*
11:10–12:10 (a) One half the group—Demonstration of Bronchogram Technique—*Dr. A. R. Curreri, Dr. L. W. Paul*
(b) One half the group—Diagnostic Clinic —State of Wisconsin General Hospital —*Dr. B. Jack Longley, Dr. A. R. Curreri*
12:00 Noon Recess
1:30– 2:10 What Should One Expect from Radiation Therapy in the Treatment of Malignant Lesions?—*Dr. E. A. Pohle*
2:10– 2:40 Cancer of Lung—Diagnosis and Therapy— *Dr. J. W. Gale, Dr. A. R. Curreri*
2:40– 2:50 Recess
2:50– 4:00 Papanicolaou Technique in Diagnosis of Cancer in Lung, Genitourinary Tract or Gastrointestinal Tract—*Dr. L. L. Swan*
4:00– 5:00 (b) One half the group—Demonstration of Bronchogram Technique—*Dr. A. R. Curreri, Dr. L. W. Paul*
(a) One half the group—Diagnostic Clinic —State of Wisconsin General Hospital —*Dr. B. Jack Longley, Dr. A. R. Curreri*

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THURSDAY, MARCH 25

9:00– 9:40 The Organization of a Successful Cancer Detection Center—*Dr. Otto V. Hibma*
9:40–10:20 The State of Wisconsin General Hospital's Cancer Diagnostic Center—*Dr. B. Jack Longley*
10:20–10:30 Recess
10:30–11:00 Cancer Research at the University of Wisconsin and the McArdle Memorial Laboratory for Cancer Research—*Dr. Harold P. Rusch*
11:00–11:30 Significance of Research in Relation to the Present Concepts of Cancer and Cancer Control—*Dr. Van R. Potter*
11:30–12:00 What Should the Layman Expect and Some Newer Diagnostic Methods—*Dr. Wm. D. Stovall*
12:00 Joint Luncheon of Physicians Group and Field Army Representatives, Memorial Union
2:00– 5:00 Field Army Program as Arranged by American Cancer Society and *Robert McLean* (Physicians in group cordially invited)

Chicago Medical Society Annual Clinical Conference

The Chicago Medical Society will hold its fourth annual clinical conference at the Palmer House, Chicago, on March 2–5. The conference represents an intensive four day postgraduate course for the general practitioner and specialist with leading teachers from all over the United States. All physicians are invited to attend, and reservations may be made directly with the Palmer House.

Michigan Postgraduate Clinical Institute

The second annual Michigan Postgraduate Clinical Institute will be held at the Book–Cadillac Hotel, Detroit, on March 10–12. A concentrated three day postgraduate course, covering the newest developments in medicine, surgery, obstetrics, pediatrics, dermatology, ophthalmology–otolaryngology, and general practice, will be presented by forty-nine outstanding clinicians and lecturers. All members of the American Medical Association and the Canadian Medical Association are invited to attend. There will be no registration fee.

COMMENTS ON TREATMENT

(Continued from page 214)

does not cause a reaction within four hours, the administration of penicillin may be resumed in full therapeutic doses, though with continued administration of the antihistamine compound. (*f*) Thereafter the attempt should be made to discontinue the antihistamine compound gradually; this may be successfully done in some instances while continuing the administration of penicillin. (*g*) It is considered advisable during the period of the trial administration of penicillin not to use it in peanut oil and beeswax but rather in a form that will be rapidly excreted should a reaction occur. (*h*) If the immediate attempt to readminister penicillin is not successful it is advised that one wait a month or more and then make another very cautious attempt if it is still considered necessary to give the drug.

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TRADE NEWS

Schering Supports Further Endocrine Research

Research grants to three leading medical research institutions for another year were recently renewed by Schering Corporation of Bloomfield, New Jersey, world's largest manufacturer of endocrine products.

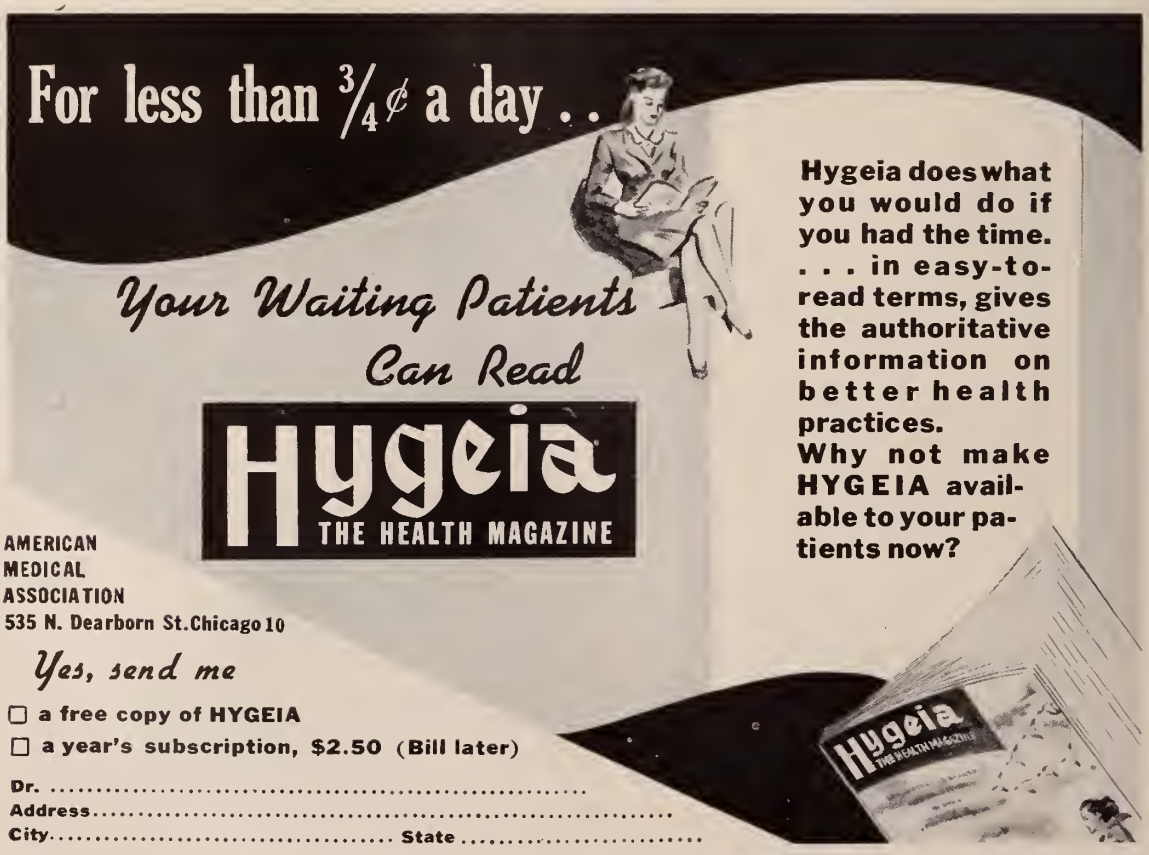
Two of the grants provided for the appointment of fellows in endocrinology at Jefferson Medical College and the University of Oregon Medical School. The third grant, for continued study on the enzyme hyaluronidase, has been awarded to Dr. Charles Birnberg of the Jewish Hospital, Brooklyn, New York. Through the past year, considerable knowledge concerning the clinical and experimental value of this unusual enzyme has been reported, and the completion of Doctor Birnberg's program of research will require another year. Similar grants in other fields of research are made from time to time to leading institutions by Schering as part of its program for the advancement of medicine.

Medicine Makers Urged to Keep Prices Down

Medicine makers were urged to aid in keeping prices down by Dr. J. Mark Hiebert, vice-president of Sterling Drug, Inc., in a panel discussion on medical marketing before the American Pharmaceutical Manufacturer's Association at the Waldorf–Astoria in December. Doctor Hiebert said the manufacturer's first consideration was "to give a new product an opportunity to succeed." Without withholding important medical discoveries from the public for business reasons, he urged concentration on comparatively few major introductions each year. In this way the money available for promotion can be more intensively and intelligently used. Too many introductions each year also serve "only to confuse the physician, the wholesaler, and the druggist."

Dr. Frank J. Stockman, vice-president of Winthrop–Stearns, Inc., participating in the same discussion, maintained that management of the pharmaceutical industry "should direct available research resources into purposeful channels and that before setting the compass, the knowledge, experience and judgment of the medical staff should be given consideration."

Others participating in the discussion were the vice-president of G. D. Searle and Company, who presided; the president of William Douglas McAdams, Inc.; and the president of the Pitman–Moore Company.



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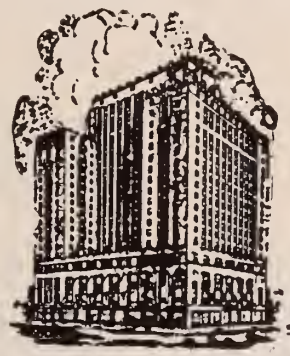

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THE WISCONSIN MEDICAL JOURNAL

P. S.: PAGE 263 LISTS THIS MONTH'S ADVERTISERS.

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	186
American Optical Co.	180
Ames	240, 241
Ar-Ex Cosmetics, Inc.	236
Audiphone Utilities	258
Ayerst, McKenna & Harrison	233
Barr X-Ray Co.	261
Benson Optical Co.	252
Bergmann Prescription Pharmacy	235
Bordcn Co.	239
Camel (R. J. Reynolds Tobacco Co.)	192, 193
Camp, S. H. & Co.	237
Central Drug	250
Ciba	187
Coca Cola Co.	231
Cook County Graduate School of Medicinc	263
Doerflinger's	258
Drekmeier Drug	235
Endocrine Laboratories	235
First Central Dispcnsary	235
Hotel Schroeder	261
House of Bidwell, Inc.	261
Hurley X-Ray Co.	256
Ivanhoc Trcatment, Inc.	267
Jensen Brothers	250
Kennedy–Mansfield Dairy	264
Lilly, Eli and Company	facing page 195
Lov-é Brassieres	253
M & R Dietetic Laboratories, Inc.	245
Mallatt Pharmacy	235
Mather Pharmacy	250
Mayer Drug	250
Mead Johnson & Co.	185, 266
Medical Protective Co.	184
Merck & Co., Inc.	182
Milwaukee Optical Co.	243
Milwaukee Sanitarium	268
National Dairy Products Co., Inc.	194
National Drug	189
Nechin, A. R. Co.	255
New World Life Insurance Co.	181
New York Polyclinic	261
Orthopedic Appliance Co., Inc.	256
Parke, Davis & Co.	178, 179, 247
Philip Morris	249
Physicians Casualty Assn.	259
Physicians and Radium Assn.	261
Pogue, Mary E. School	258
Prescription Pharmacy	235
Radium Service Corporation	263
Rennebohm Drug Stores	235
Rentschler Floral Co.	264
Roemer's	259
Rogers Mcmorial Sanitarium	268
Sacred Heart Sanitarium	254
St. Croixdale Sanitarium	181
Schering Corporation	191
Schlintz Bros. Drug Store	250
Searle, G. D. & Co.	227
Shorewood Hospital Sanitarium	231
Smith–Dorsey Company	183
Summit Hospital	243
Swift and Company	188
Uhlemann Optical Co.	251
Wander Co.	190
Winthrop–Stcarns, Inc.	229
Zemmer Co.	238

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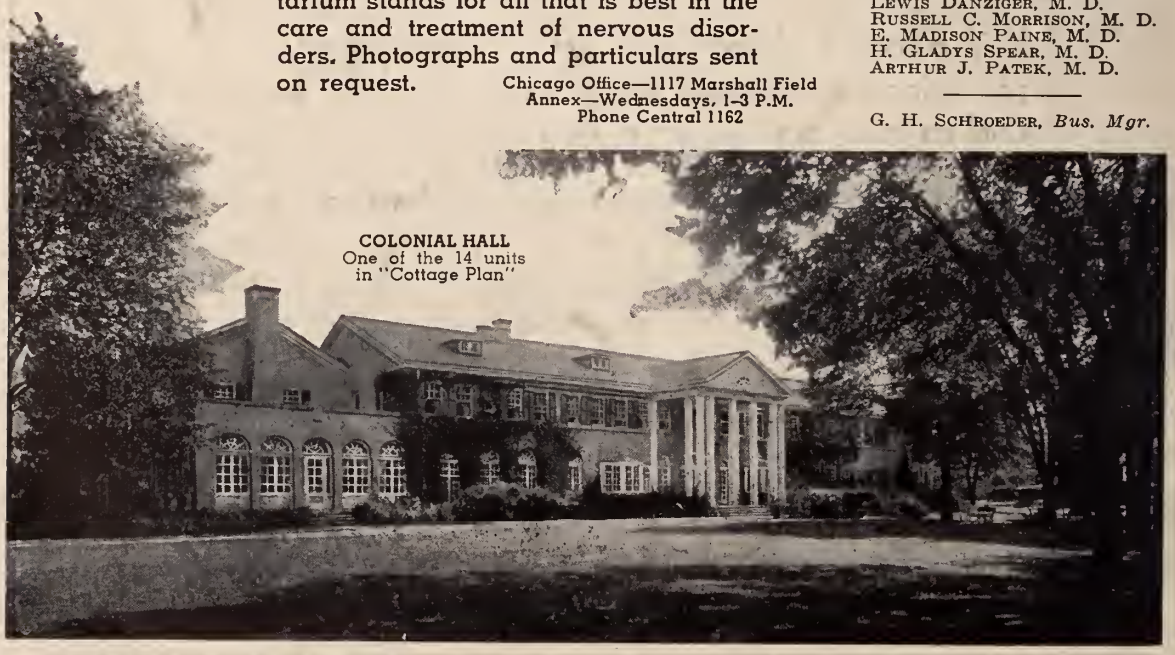

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By James H. Bloomfield, M. D.

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By Marc J. Musser, M. D.

THE CLINICAL MANAGEMENT OF EDEMA
By H. W. Pohle, M. D., and N. W. McKittrick, M. D.

AN OUTLINE OF PROCEDURE FOR ROUTINE ROENTGENOLOGIC GASTROINTESTINAL EXAMINATIONS
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TABLE OF CONTENTS, PAGE 272

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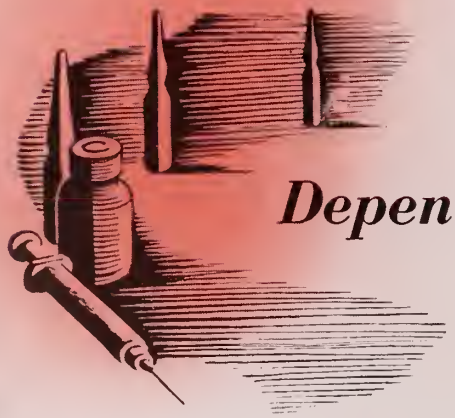

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Management of Late Hemorrhages of Pregnancy, by James H. Bloomfield, M. D., Chicago	287
Some Psychosomatic Aspects of Thyrotoxicosis, by Marc J. Musser, M. D., Madison	291
The Clinical Management of Edema; Based on Five Year Experience With Sodium Control, by H. W. Pohle, M. D., and N. W. McKittrick, M. D., Milwaukee	294
An Outline of Procedure for Routine Roentgenologic Gastrointestinal Examinations, by C. F. Sherman, M. D., Madison	296
Generalized Scleroderma; Report of a Case, by Anthony N. Ries, M. D., Evanston, Illinois	299
Comments on Treatment	306
Notes on Clinical Pathology	307
As It Looks to Your State Board of Health	312

EDITORIAL

	Page
Physician Shortage and Medical Care, by John S. Hirschboeck, M. D.	311

MISCELLANY

	Page
As It Looks from the Committee on Nursing Problems of the American Medical Association, by Thomas P. Murdock, M. D., Meriden, Connecticut	308
The President's Page	309
Tumor Clinic Opens at the State of Wisconsin General Hospital March 15, 1948	313
Second Annual Cancer Symposium of the Medical Society of Milwaukee County	314
Recent Wisconsin Licentiates	315
Society Proceedings	318
News Items and Personals	320
And About the Third and Twelfth Districts	322
Society Records	326
Deaths	328
Correspondence	330
The Woman's Auxiliary	332
The Journal Bookshelf	338
Physicians' Exchange	354
Index to Advertisers	356
List of Executive Officers of County Medical Societies	357

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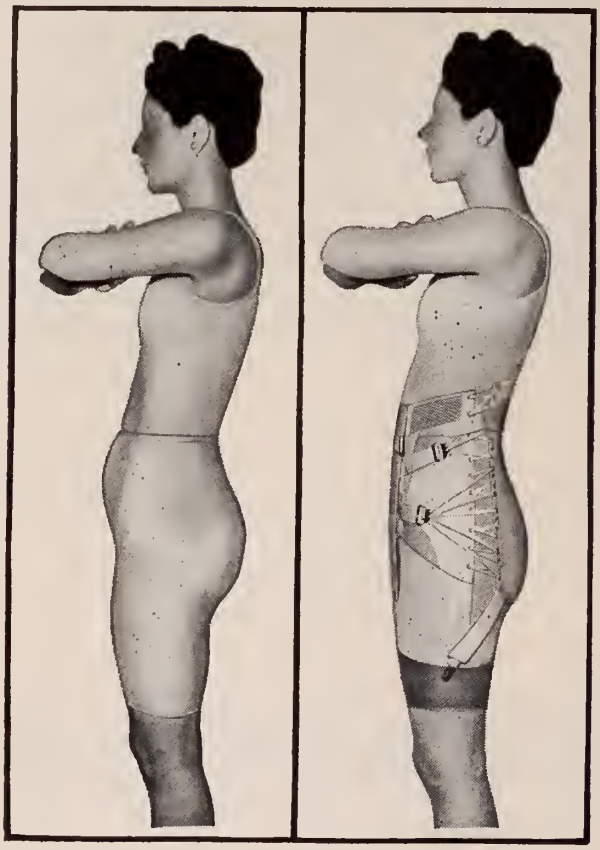

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2. Feinberg, S.M., and Friedlaender, S., Am. Jl. Med. Sci. 213:58, Jan. 1947.
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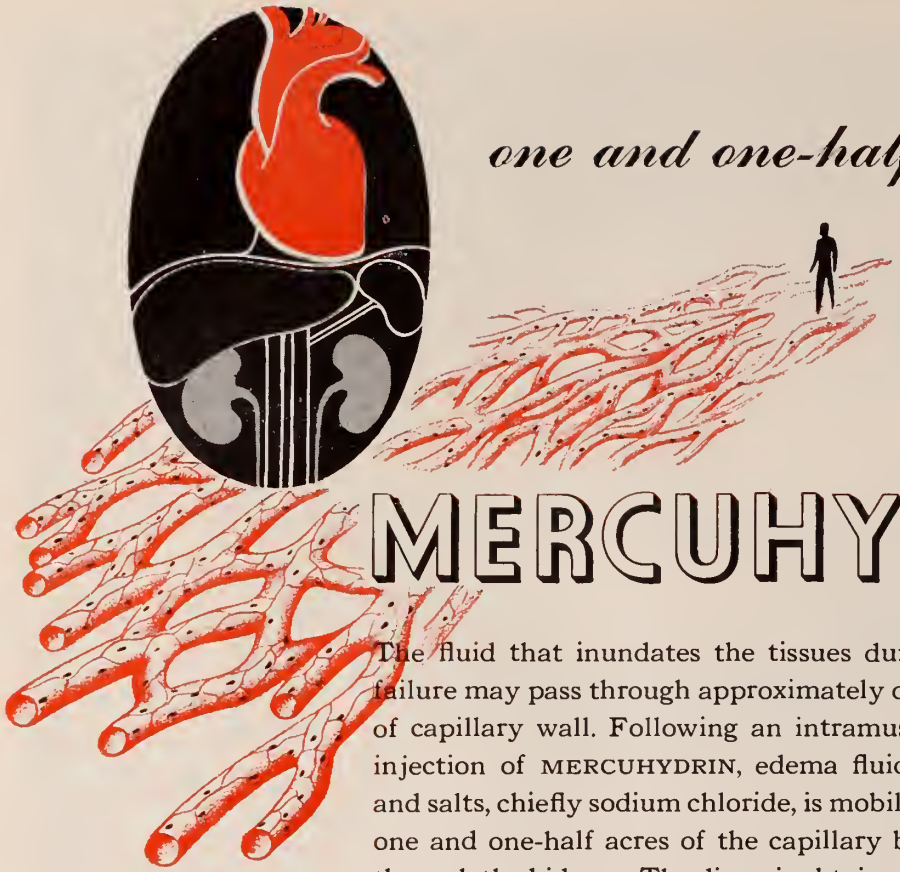

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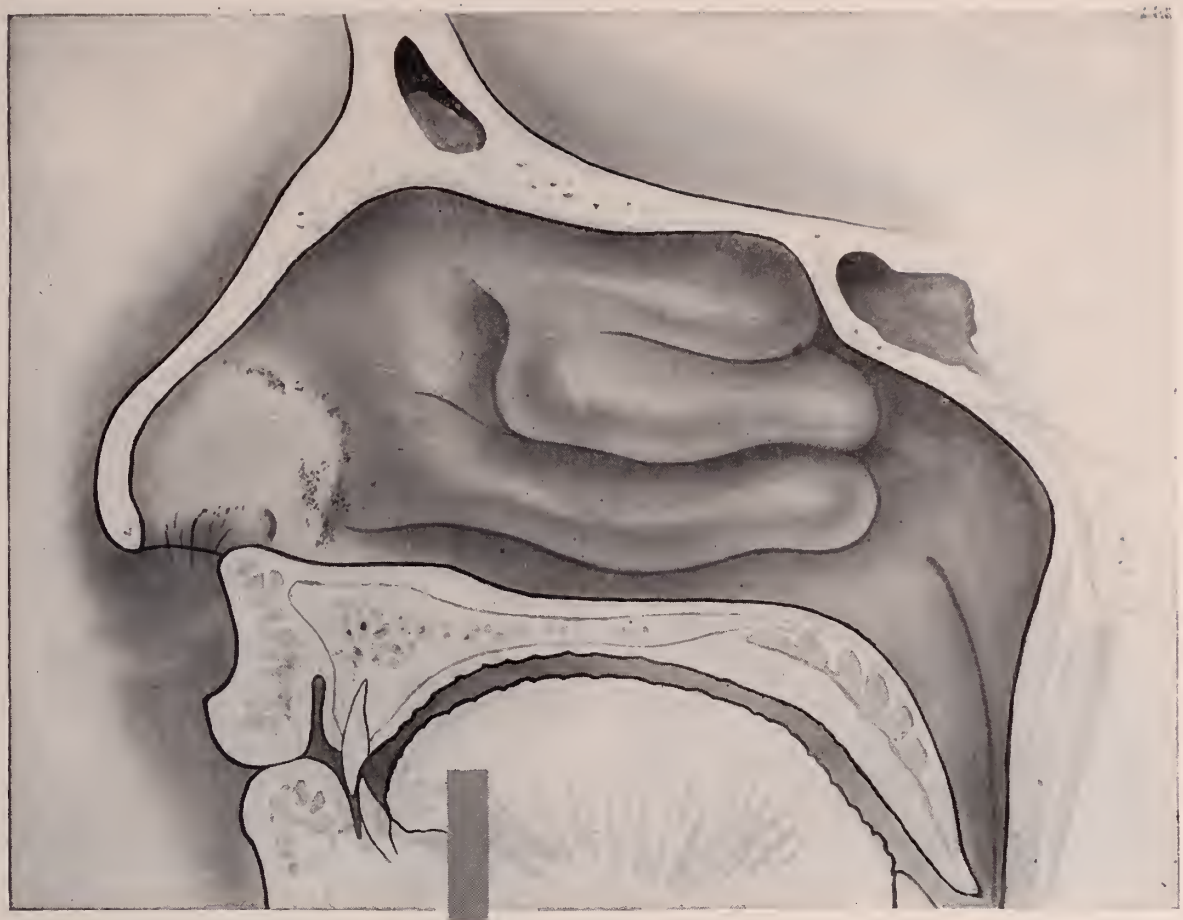

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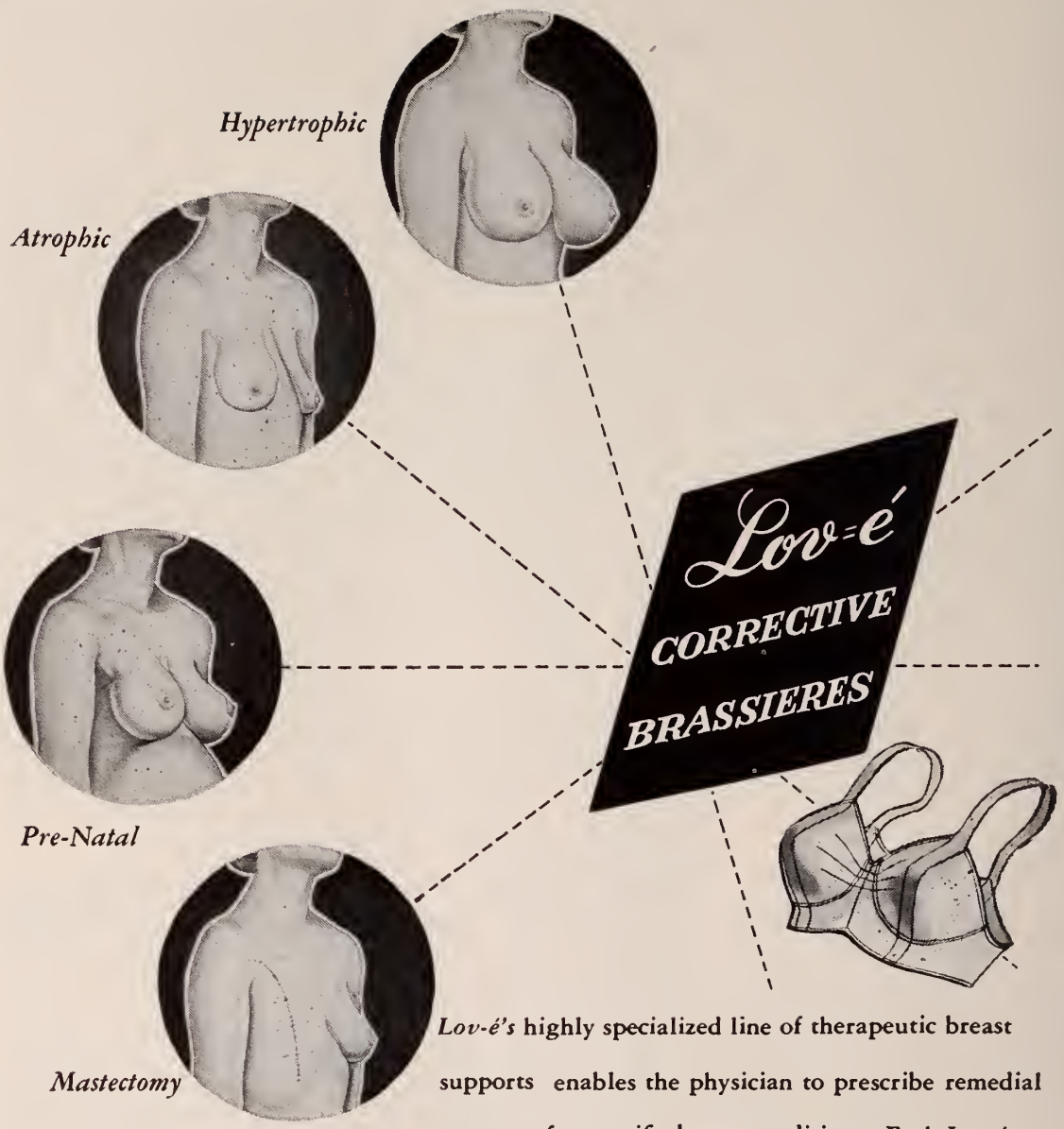

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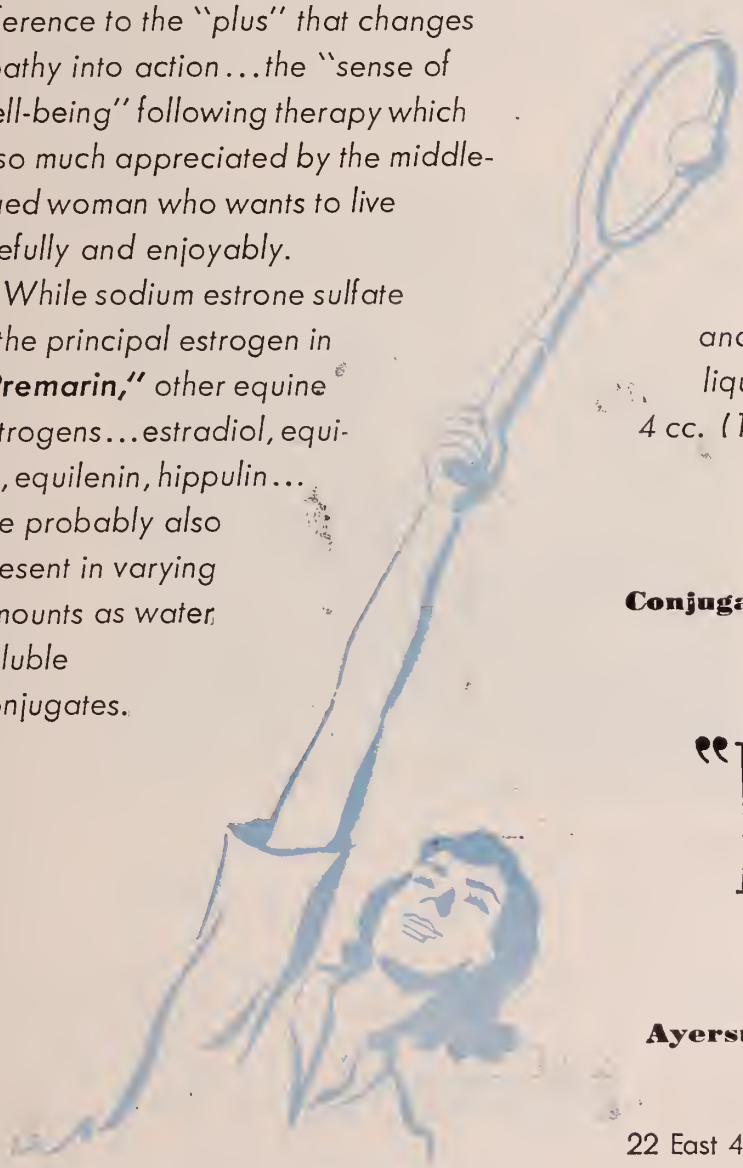

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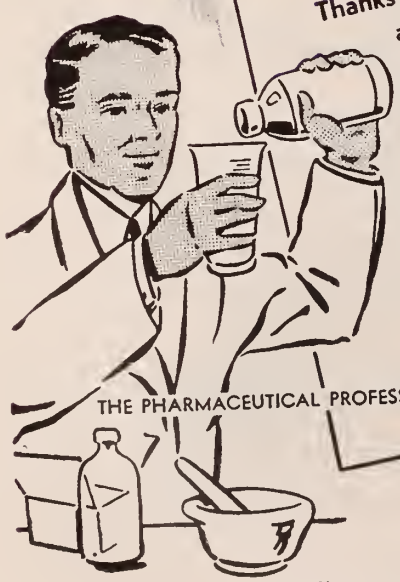

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Management of Late Hemorrhages of Pregnancy*

By JAMES H. BLOOMFIELD, M. D.
Chicago

J. H. BLOOMFIELD

Doctor Bloomfield, a native of Michigan, graduated from the University of Illinois College of Medicine in 1913. He served as an intern and resident at the Chicago Lying-In Hospital, where for many years he was associated with the late Dr. J. B. DeLee. Since 1931 he has been in the obstetric department of Passavant Memorial Hospital. At present he is assistant professor of obstetrics at Northwestern University Medical School.

THE criteria of deaths in pregnant women lists sepsis, hemorrhages, and toxemia in given order. If a careful analysis were made including early abortions, I am sure hemorrhages would rank first. A greater number of sepsis cases would not occur if a patient's resistance had not been lowered by loss of blood previously. The autopsy findings and death certificates show only the final tabulation. Health administration officials, in all probability, and with sincerity, look upon sepsis as being more preventable than unpredictable hemorrhages during pregnancy and labor. There is little doubt, however, that sepsis and hemorrhage carry a strong relation to each other.

The two great causes of hemorrhage during the last trimester of pregnancy are low-lying placenta and ablatio placenta. Secondly, and certainly less severe, we must include cervical polyps and carcinoma of the cervix. We cannot emphasize too strongly the necessity of a thorough examination of the cervix in the early months of pregnancy in order to eliminate the bleeding of threatened abortion. Erosions of the cervix may bleed, but personally I have never had a private case in which I could say the condition was the cause of hemorrhage. I have seen 2 cases in which large varicosities of the vagina ruptured late in pregnancy with considerable blood loss before the correct diagnosis was made. A firm vaginal pack controlled the bleeding very easily, and no dissecting hematoma occurred. Any patient who has even a moderate blood loss after the sixth month of pregnancy, due to a low-lying placenta or a placenta separation, should immediately be hospitalized, and a correct diagnosis be made at once. This is not always easy to differentiate, as the textbook pictures make us believe. If there is any distance to be covered to reach the hospital, it is certainly on the side of safety to pack the vagina firmly and apply a firm abdominal binder. This will diminish blood loss and is the fundamental treatment for late hemorrhages. The patient should then have a complete blood work-up at once for possible transfusion. In the meantime other fluids like plasma, glucose, or saline may be started, the amount given depending on the general condition of the patient and amount of blood loss; however, there is no substitute for whole blood in hemorrhaging of pregnancy, regardless of the cause.

A thorough, careful vaginal examination under most aseptic conditions is then in order. The operating room is made ready to handle any emergency by the vaginal route. By this we mean that Voorhees' bags, perforator, and packing are readily available. The procedure from now on depends entirely on the findings of the examination. The treatment depends on the type of placenta praevia found or ablatio placenta.

The tendency in the past few years has been to deliver the patients in a great majority of cases of hemorrhage by the abdominal route. The use of bags for the control of bleeding is becoming more rare; yet they should not be entirely discarded, as they have a very definite place in obstetrics in selected cases. The same can be said of the Braxton Hicks version. Either procedure may be a life-saving operation when an immediate abdominal operation cannot be performed.

Let us first consider placenta praevia, as the treatment varies considerably from that of ablatio placenta. At the first examination the type or degree of praevia should be determined and also the amount of dilatation and the condition of the cervix. Also an inspection of the cervix through a speculum is necessary to eliminate bleeding from a polyp, carcinoma of the cervix, or ruptured varix of the vagina. Very rarely—and then only during labor—will a velamentous insertion of the cord rupture and bleeding follow. The membranes, of course, would have to be ruptured for bleeding to become visible. The type of praevia described by most authors and

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

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teachers should be changed, as it is only relative if the patient is in labor.

A marginal praevia before labor may give the obstetrician the false impression of being a central placenta praevia, but once the cervix starts dilating it becomes only a lateralis; consequently, the degree of praevia depends entirely on whether the patient is in labor or not, and, therefore, it becomes only relative. We could very well do without the term "marginal placenta praevia."

DeLee so ably described the objects to be accomplished in the treatment of placenta praevia when he wrote: "The first and most urgent is to stop the hemorrhage. The second is to empty the uterus. If the bleeding is under control, there is no great hurry in emptying the uterus, and in the interval the anemia may be combated by the use of either blood or other fluids. The third is to insure hemostasis. Many a patient has had the uterus emptied only to bleed to death afterward when the hemostasis had not been insured. The fourth is to combat the anemia."

As previously stated, there is no fluid that takes the place of blood, and at the same time there is very little common sense to be used in the administration of whole blood or fluids if it is to be filtered through from below. It does the patient very little good and is certainly of lost value. It is always better to replace the blood lost with a greater amount than has already been lost than to give too little. The most important object then is to stop the hemorrhage. We have three methods which are the most useful and simple for combating hemorrhage. First, if it is a marginal or lateral placenta praevia or a low-lying placenta, the simplest method is simply to rupture the membranes. The presenting part, whether it be the head or the breech, will compress the placenta against the uterine wall and will stop the hemorrhage. If it is a placenta praevia centralis, simply rupturing the membranes and perforating the placenta should not be considered. It then becomes necessary to do one of two things. Either the placenta may be perforated and a bag inserted, and this may cause a considerable amount of blood loss at the time,—or, if the cervix is sufficiently dilated to admit two fingers, a Braxton Hicks version may be done providing it is a cephalic presentation. If we are fortunate enough to find a breech presenting, it becomes much easier for the rapid control of hemorrhage. The insertion of the bag or a Braxton Hicks version is a sure method for the control of hemorrhage; yet at the same time it gives us a very high fetal mortality. In other words, the baby becomes of secondary importance. This is done entirely in the interests of the mother. There should never at any time be a rapid delivery following the bag insertion or a Braxton Hicks version. We must then wait for the cervix to dilate normally and fully before attempting to do a delivery.

One of the greatest mistakes that can be made is to attempt a delivery of the baby in the hope of obtaining a live birth in a placenta praevia in which the cervix is not fully dilated. The cervix is very comparable in consistency to a placenta; it is very easily torn, and these tears may extend upward to the base of the broad ligaments; we may possibly deliver a live baby only at the expense of the death of the mother from severe hemorrhage. Of late years the use of Willett's forceps in lateral, marginal, and low-lying placentas has become a recognized treatment. It is to be highly recommended in those cases in which the membranes can be ruptured and the forceps attached to the baby's scalp. In other words it has replaced the use of the bag in the treatment of a certain type of placenta praevia. It is not to be recommended in placenta praevia centralis or totalis. I am sure that we will be able to deliver more live babies with the use of the Willett's forceps than we will with the use of the Voorhees' bag. The other method, of course, resolves itself into the abdominal sections.

It is well to remember that the lower the placenta is attached in the uterus, the earlier will be the first hemorrhage from placenta praevia. Very seldom will they occur before the sixth month, more often from the seventh month on. The first hemorrhage from placenta praevia is usually not severe. If the fetus is not viable, we may temporize for some days or weeks until viability is approached providing the patient is in the hospital, where, if a secondary hemorrhage, which is usually more severe, should occur, immediate steps may be taken for delivery. I am in hearty approval of the abdominal method for the treatment of placenta praevia. There is, of course, no question about the increased number of live fetal births by the abdominal route over the vaginal route. In primiparas, when the cervix is not effaced or dilated, I consider cesarean the ideal method of delivery. In multiparas when the cervix is soft or in whom there have already been babies previously delivered vaginally, abdominal section is contraindicated. If the sacrificing of a baby be considered, vaginal delivery may be attempted. In all cases of placenta praevia centralis, I consider the abdominal route the safest method for delivery. Its only drawback that we should consider is the fact that we have scarred the uterus, which may necessitate future deliveries by the same method. This is not necessarily true, but especially it should be thought of in cases of placenta praevia in which the suturing of a uterus has been done, especially in the lower uterine segment, where approximation may not be perfect. Many obstetricians hesitate about doing a low cervical cesarean in placenta praevia, and prefer the old classic type of operation instead. Personally, I have always felt that I have been more capable of controlling a hemorrhage from a placenta praevia by the low cervical method than by the old classic type of operation; therefore, I heartily recommend the low cervical type of operation.

The question often comes up when we have a placenta praevia and are dealing with a dead fetus.

The method of choice, if this is at all possible in these cases, is to deliver them by the vaginal method, if it is possible to insert a bag or do a Braxton Hicks version. The hemorrhages in all cases of placenta praevia can be controlled by this method if the cervix is dilated enough so either operation may be performed. Occasionally it becomes too dangerous a risk, and while we would hesitate, the abdominal route in these cases would be the operation of choice, because it might save a marked loss of blood; the only handicap would be a dead fetus and the fear of a second operation at future pregnancies. If a patient is near term, that is, beyond the twenty-eighth week and before the fortieth week of pregnancy, and the heart tones are good, if the patient is in a well equipped hospital, and a competent surgeon present, I consider that the proper treatment for placenta praevia is cesarean section.

Now let us take up the matter of ablatio placenta. Treatment varies only slightly from that of placenta praevia. This condition constitutes an important item in the list of serious complications of pregnancy. The causes remain obscure, and the methods or prevention are uncertain. In approximately 95 per cent of the cases it is associated with a toxemia or a cardiovascular pathology. Trauma constitutes the other 5 per cent. A great many cases may become a very serious matter with only slight signs of toxemia or with such slight symptoms that they are not considered serious even during the course of the usual prenatal care. It is true that in the majority of cases we will find a marked albuminuria and a staircase elevation of blood pressure present. The diagnosis is most often confused with placenta praevia. These may offer considerable difficulty in diagnosis, especially in the absence of the classic symptoms of shock, external bleeding, firm uterus, and dead fetus. Fortunately, such cases are comparatively rare, but a correct diagnosis is extremely important if errors in treatment are to be avoided. With a careful examination and history a diagnosis is possible in all but a few cases. In rare cases, in which the diagnosis cannot be made, the use of an intraovular bag or abdominal delivery will fulfill the indications for either condition. In premature separations the amount of uterine damage from hemorrhage into the muscle wall varies greatly, and no method has been proposed to determine this amount before delivery. In the most severe types, often seen late, the uterus has lost all power of contraction. It has been said that in cases in which the hemorrhage has extended outside of the uterus into the broad ligaments marked tenderness in the flanks should at least arouse suspicion that the hemorrhage has extended beyond the uterus itself. In the milder cases, the hemorrhage is usually intrauterine, or at the most only a portion of the uterus may show signs of blood infiltration. It is the uncertainty of the amount of blood extension that has led to the use of the abdominal delivery in ablatio. The symptoms are not always suggestive of the amount of damage that has already been done.

Premature separation differs from placenta praevia in that to stop hemorrhage effectively the uterus must be emptied, and although rapid delivery is desirable, accouchement force carries with it the almost inevitable addition of loss of blood. Such patients should under no circumstances be subjected to Braxton Hicks version, and it is always contraindicated because it cannot be followed by an immediate extraction, and increases the loss of blood.

The object in premature separation is the same as in placenta praevia, that is to control the bleeding as much as possible until the uterus can be emptied, by which method depends entirely upon other circumstances and also upon the skill of the operator. We have only two methods: the application of a bag with a tight abdominal binder or a cesarean section. It is then impossible to predict in any given case whether or not the uterus will contract sufficiently after it is emptied to control postpartum hemorrhages. In every ablatio placenta that has been delivered from below, in my opinion, the uterus should be firmly packed. We have always made it a rule that if bleeding occurs through the packing, it may be packed the second time. At the same time the patient should receive supportative treatment with blood plasma and other fluids, but if it bleeds through the second packing, we are dealing undoubtedly with a Couvelaire uterus; then if the hemorrhage should continue, an abdominal operation and the removal of the uterus should be instituted at once.

Waters has brought forth a very useful procedure if we use the abdominal method of delivery and if the uterus fails to contract. He simply ligates the uterine arteries by the use of a large aneurysm needle, and it is a mass ligation. The uterine arteries are not dissected free, but are simply ligated in mass. That stops the flow of blood into the already damaged uterine wall. At least it is safe from then on to increase the amount of blood transfusion. This may require an enormous amout of blood. Anywhere from 1,500 to 3,000 cc. of blood may be necessary. In toxemic patients the shock is not so great as it is in those cases in which trauma is the cause of premature separation. The blood pressure may drop anywhere from 50 to 100 points in a toxemic patient without showing the symptoms of shock that we will find with a drop of 40 or 50 points in traumatic cases. The shock must be combated, the blood pressure must be maintained, the hemorrhage must be controlled. If a uterus fails to contract after it is emptied or if there is a marked infiltration extending outside the uterus, then a hysterectomy should be performed. In 1 case which I had an opportunity to see, the blood had extended through the broad ligaments over the brim of the pelvis and extended as far upward as the kidney area. This was unfortunately brought out at postmortem findings. Even the use of pituitrin, ergotrate, or any other oxytocic drugs may be only a temporary relief as far as contraction of the uterus is concerned. The uterus must be watched for many hours for subsequent bleeding.

I have seen several cases of ablatio placenta due to trauma. My belief is that these patients are insured a greater degree of recovery if the uterus is removed at the time it is emptied by the abdominal method. It is rather interesting to note that from a great many clinics throughout the country there is very little difference in the mortality rate to the mother who is delivered abdominally or by the vaginal method.

Again I would like to quote some statistics from the Cook County Hospital. The method varies little from that time until the present time regarding treatment. For the years 1940 and 1941 we had a general admission of 10,171 obstetric cases. We had a gross fetal mortality of 4.96, with a corrected fetal mortality of 1.63. We had a total number of 37 ablatio placentas. The corrected cases included all macerated feti, previable feti, and feti entering the hospital without fetal heart tones. The age incidence in ablatio was from 16 to 45 years of age with 31 to 35 being the greatest age incidence. We had 7 primiparas and 30 multiparas; para III's carried the greatest incidence in parity. Unfortunately, 26 of these patients had no prenatal care, which brings out, of course, the fact that this may be more or less a preventable disease. The period of gestation from the sixth to the ninth full month showed that the seventh and eighth month of pregnancy was the most liable for ablatio to occur. We only had 6 cases out of 37 that showed no symptoms of toxemia. Out of 37 cases we had 2 maternal deaths. The treatment instituted in these 37 cases was bag insertion in 9 and expectant treatment in 21. We had 6 cesarean sections, including 2 Porro and 3 Couvelaire uterus, of which the 2 Porro were removed. One had no treatment, and all patients had transfusions expect 1. The symptoms in 37 cases, most marked upon admission, were pain with bleeding in 30 cases, bleeding without pain in 5 cases, and pain without bleeding in 2 cases. In the cases of the 2 maternal deaths, the patients had no prenatal care, and both were admitted in profound shock. One died one-half hour after entrance to the hospital, although shock was treated and transfusion was instituted immediately.

The second patient was a 33 year old white female, a gravida iv, para iii, at term, with no prenatal care, who had been bleeding for twenty-four hours and had had eight eclamptic convulsions. She delivered immediately after entrance into the hospital of a full term, stillborn infant and placenta simultaneously with a large retroplacental clot. She expired eighteen hours later of complete anuria and cardiovascular failure. Our fetal mortality was 29 natal deaths, or 76.4 per cent. Of these, 25 could be corrected out, giving us a fetal mortality of 13.5 mortality. The expectant treatment in all these cases when the patient was not in labor and in good condition was immediately to institute labor and transfusions. The bag was used in these cases, and tight binders were applied to the abdomen. In both placenta praevia and ablatio placenta the uterus must be watched closely for delayed hemorrhage. It is my opinion that they should be packed firmly and uterine stimulants given. The uterus following placenta praevia is not quite so liable to bleed as it is from abruptio, but if there is any bleeding at all, it should be packed the same as in ablatio. Statistics will show that there is very little difference in ablatio placenta as far as maternal mortality is concerned whether the patient is delivered by abdominal or the vaginal method. I am sure that we all have seen cases in which convalescence following delivery by the abdominal method in abruptio has been rather stormy. My own opinion is that for patients who have ablatio placenta, especially of the Couvelaire type or the toxic type, we should consider hysterectomies at the time of operation. The important thing following, of course, is to combat toxemia, anuria, and the replacement of blood; again there is nothing that can take the place of whole blood. Plasma and other fluids give temporary relief, but will not fulfill entirely the whole blood that should be used. The treatment of shock is well known.

A recent statistical analysis of 895 cesarean sections at our own hospital, performed by various staff obstetricians, showed 53, or 5.9 per cent, were done for placenta praevia, and 25, or 2.7 per cent, for ablatio.

WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

The fortieth annual meeting of the Wisconsin Anti-Tuberculosis Association will be held May 17 and 18 at the Hotel Pfister, Milwaukee.

The business meeting will be held on the morning of May 17, followed by three half-day sessions devoted to (1) What's Ahead in Tuberculosis Case-Finding, Treatment, and Rehabilitation; (2) Housing and Economic Needs of Tuberculous Families; and (3) Health Education and Tuberculosis in General Hospitals.

High point of the program will be an address at the annual dinner on May 17 by Dr. James E. Perkins, new managing director of the National Tuberculosis Association. Other outstanding speakers will be announced later.

Some Psychosomatic Aspects of Thyrotoxicosis*

By MARC J. MUSSER, M. D.
Madison

M. J. MUSSER

A graduate of the University of Wisconsin Medical School in 1934, Doctor Musser is now associate professor of internal medicine at that institution. From 1941 to 1945 he served in the Army Medical Corps, attaining the rank of colonel.

THE growing emphasis of the influence of emotions upon the functions of the body has encouraged closer scrutiny of a group of diseases which for many years have frustrated the efforts of the medical profession to establish their etiology, pathogenesis, and proper treatment. Much evidence has already accumulated to indicate that such diverse conditions as asthma, hypertension, peptic ulcer, ulcerative colitis, migraine, and thyrotoxicosis have as a part of their symptom complex an emotional component which is significant both etiologically and symptomatically.

The relationship of emotional disturbances to disease is the basis of what has come to be known as "psychosomatic medicine." This has been defined by Stanley Cobb[1] as a "clinical field that takes up the study of the abnormal functions set going by emotional stimulation in any system of the body and the study of the lesions caused by such abnormal functioning." In brief, it more clearly establishes emotional disorders as an etiologic agent, capable of producing physiologic changes and organic disease.

For psychosomatic evaluation, the establishment of three details is necessary: (1) the personality of the patient, (2) the nature and cause of the emotional disorder, and (3) the nature of the physiologic and organic disturbance. With sufficient search, some emotional factors will be found to accompany almost every illness. They become of etiologic importance only when a clearcut cause and effect relationship exists between them and the somatic manifestations. In such instances the total personality of the patient usually is such as to facilitate the development of a significant emotional disturbance.

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

A relationship between emotional reactions and thyrotoxicosis has been recognized for years. Recent studies have significantly enlarged our knowledge of the subject. Other circumstances are also important. It cannot be conclusively stated that thyrotoxicosis is entirely a psychosomatic disease.

The function of the thyroid appears to be controlled by an extremely labile and sensitive endocrine and neurogenic mechanism. Secretory activity of the gland is stimulated by the thyrotropic fraction of the anterior pituitary secretion. This influence is regulated by a reciprocal inhibitory action of thyroxin, or some combination thereof. There is evidence to indicate that other endocrine glands, especially the adrenals and gonads, exert an influence upon this pituitary-thyroid inter-relationship. Neurogenic influences appear to be mediated through the hypothalamus and sympathetic nervous system. More concise knowledge of neurophysiology, especially autonomic representation in the frontal lobes and the significance of the frontothalamic radiations (particularly in regard to their influence upon effective emotional reactions), suggests that the cerebral cortex may play a role in the mechanism. Normally, this mechanism operates with a fine balance in the adaptive reactions of the body to the various stresses and strains exerted upon it. It has been demonstrated that this balance can be disturbed by such widely different factors as environmental temperature, seasonal fluctuations, adolescence, pregnancy, infection, lack of iodine, physical, and emotional trauma. How the influence of these factors is mediated is unknown. Normally, when the disturbing stress is removed, the balance of the pituitary-thyroid mechanism is restored. It remains to be explained why, in thyrotoxicosis, the balance continues to be distorted.

Psychologic Factors in Thyrotoxicosis

Of the significance of the psychologic factors, Bram[2] in 1929, after reviewing 3,343 cases of thyrotoxicosis, reported that 85 per cent of them presented a clear history of psychic trauma as the exciting cause of the disease. Marañon,[3] Bauer,[4] and others have concluded that psychologic shocks could precipitate thyrotoxicosis. The relative importance of acute or chronic emotional stress has been argued. Lewis[5] has pointed out that all the symptoms of thyrotoxicosis, chemical, physical, and psychologic, are exact duplicates of fear and anxiety states found in animals and concluded that exophthalmic goiter was an exaggerated form of anxiety neurosis. The validity of this latter observation has been exposed to question by Cannon's classic work. He demon-

strated that certain emotional manifestations of man and the fighting and defense reactions of animals were actually sympathoadrenal effects. These produced, characteristically, pupillary dilatation, protrusion of the eyeballs, cutaneous vascular and smooth muscle constriction, accelerated heart rate, decreased gastrointestinal activity, tremors, and sweating. Similar as some of these manifestations are, they are not entirely those of thyrotoxicosis.

More recent studies have been directed toward an evaluation of the total personality structure of the individual in whom thyrotoxicosis develops. Thompson[6] and Wholey[7] have pointed out that pre-existing personality disorders may be precipitated into clinical activity by thyroid disturbances. Mittelmann[8] found that a certain number of his thyrotoxic patients had stable, well adjusted personalities and entirely adequate emotional reactions. The majority, however, could be classified as psychoneurotic or hysterical types. A similar differentiation has been made recently by Ruesch[9] and his co-workers. By their comprehensive studies, they found that the onset of thyrotoxic symptoms was frequently associated with maladjustment to environmental stresses and strains. Consistently in their patients, this apparent lack of ability to adjust to changes in environment was characteristic. They were unable to state whether it was due to impairment of the individual's adaptive behavior by disturbed thyroid function, or whether the maladjusted individual was more susceptible to thyroid disease. Actually, environmental maladjustment is the precipitating factor in many psychoneuroses and psychosomatic diseases.

Thyrotoxicosis most commonly occurs during two periods in life which present unusually difficult problems of adjustment. Early, from the late teens through the third decade, the individual is required to accept adult responsibilities and is exposed to the stresses of competitive living, marriage, and more critical interpersonal relationships. Later, between the ages of 40 and 60 years, the even more serious problems of approaching old age and death, impairment of physical appearance, isolation and separation from children, friends, and family appear. In these same periods, the highest incidence of personality disorders, psychoneuroses, and psychoses also occurs.

The Clinical Problem of Thyrotoxicosis

The problem of thyrotoxicosis must be broken down into the consideration of: (1) the thyrotoxic patient without an emotional disorder, (2) thyrotoxicosis with an accompanying emotional disorder, and (3) the large and heterogeneous group of emotional disturbances with somatic manifestations similar to the signs and symptoms of thyrotoxicosis.

The thyrotoxic patient without an emotional disorder requires little discussion. Without evidence of environmental maladjustments, personality or emotional disturbances, consideration of symptoms and signs alone will suffice. Response to appropriate therapy, be it thyroidectomy, radioactive iodine, or thiourea derivatives, will be satisfactory with but few exceptions.

On the psychosomatic service of the State of Wisconsin General Hospital the more difficult problem of the relationship of emotional disturbance to thyrotoxicosis has been encountered frequently.

In evaluating these patients it early became apparent that the nature and severity of the symptom precipitating psychic trauma or the existing emotional reaction was of little value in the differentiation between organic or psychogenic disease. Only by assuming a constitutional predilection or organ inferiority could the development of thyrotoxicosis in one patient and an anxiety-tension state in another be explained.

Among the truly thyrotoxic, however, the tendency for the precipitating psychologic stress to be the first to produce a severe emotional reaction in a previously stable or untested individual was observed. Thus a woman of 49 years, after a happy and uneventful married life devoid of emotional crises, became thyrotoxic after a long ordeal of nursing an invalid relative. Upon his death, the will, favoring the patient, was contested. During the embarrassing and extremely unpleasant court procedure which followed, her symptoms began.

Another woman of 53 years had been throughout her life a retiring, dependent, worrisome type of person. Under the protective influence of her parents and later her husband, she had maintained a reasonably stable emotional balance. Thyrotoxicosis and a moderately severe emotional disturbance developed as she became deeply concerned and involved in her daughter's disastrous marriage.

The patient with an anxiety-tension state or hysterical personality whose somatic symptoms resemble thyrotoxicosis usually presented a somewhat different problem. Long-standing maladjustment and emotional instability were common, and frequently a consistent and characteristic pattern of emotional and somatic reaction to environmental stress and strain was apparent. Often, this pattern could be recognized in the patient's childhood and adolescent reactions. In older patients, histories of lifelong maladjustments, recurrent illnesses, and multiple operations were not infrequent. In some, an earlier diagnosis of thyrotoxicosis had been made. Thyroidectomy, sometimes repeated, was consistently of only temporary or no benefit. A typical patient was a woman of 35 years who presented the symptoms and some of the signs of thyrotoxicosis. She had reacted with intense fear, anxiety, and somatic symptoms to the crises of an insecure and traumatic childhood dominated by an alcoholic and brutal father. At 18 years, after an especially harrowing experience, she became very ill, was thought to be thyrotoxic, and although thyroidectomy was performed her symptoms persisted for one year. Subsequently, similar but less severe symptoms appeared

following difficult environmental situations. Finally, after a beating by her alcoholic husband she again collapsed completely. With psychotherapy her symptoms subsided and she stabilized considerably.

Another woman of 52 years presented a somewhat different pattern. Always overly sensitive, insecure, dependent, and prone to ill health, asthenia, weight loss, tachycardia, fullness in the throat, nervousness, and emotional instability developed when her first marriage became unbearable. Following a recommended divorce and return to a sympathetic family, she rapidly regained her health. Some years later, the same symptoms reappeared when her second marriage became intolerable. After separating from her husband with the approbation of her minister, she gained 14 pounds in ten days.

This tendency toward a pattern of reaction is of important significance in the evaluation of clinical symptoms and signs. When present, a diagnosis of thyrotoxicosis should be made with caution and only in the presence of unequivocal evidence of the disease.

The laboratory may or may not be of assistance in differential diagnosis. Many emotionally disturbed patients will have an elevated basal metabolic rate. Levels between plus 20 and 30 are common; higher rates are not unusual. The determination of the total serum iodine, and especially the protein bound serum iodine, has been utilized increasingly as a dependable means of determining excessive thyroid activity. However, Wittkower, Scheringer, and Bay[10] have reported total serum iodine levels elevated 20 to 100 per cent over the normal in emotionally disturbed patients. The percentage of absorption of tracer doses of radioactive iodine by the thyroid appears to be an entirely dependable means of determining toxicity, but unfortunately the procedure is not yet generally available.

Electrocardiographic changes attributed to thyrotoxicosis may be confused with those due to autonomic unbalance.

The long-used trial of bed rest and iodine administration may well be misleading, for under the same management the emotionally sick patient may and frequently does make rapid improvement.

The nature of the patient's illness significantly influences the choice and results of therapy. Ruesch,[9] after evaluating postoperative results in thyrotoxic patients, concluded that while surgical procedures were tolerated exceedingly well by the emotionally stable group, delayed recovery was almost a probability in anxiety types and hysterical personalities. Our experience has been similar. These latter patients are better treated with the thiourea derivatives or radioactive iodine and psychotherapy directed toward correction of the emotional or personality disturbance. Psychotherapy provides the only means of doing any permanent good for the patient whose psychosomatic illness only simulates thyrotoxicosis.

Every patient presenting symptoms and signs of thyrotoxicosis deserves the benefit of careful psychosomatic evaluation. This appraisal of the patient as a whole allows for a clearer diagnosis of the existence of the disease, for an appreciation of the emotional and environmental factors which may be influencing it and for a more satisfactory determination of the therapeutic approach. It significantly facilitates proper evaluation of laboratory data. It is the only means by which emotional illnesses and personality disorders can be earlier recognized and treated, thus minimizing the problem of chronic psychologic invalidism.

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WISCONSIN STATE BOARD OF MEDICAL EXAMINERS

A meeting of the Wisconsin State Board of Medical Examiners will be held April 22–23 at the Hotel Loraine, Madison, for the purpose of examination of reciprocity applicants.

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The Clinical Management of Edema

Based on Five Year Experience With Sodium Control

By H. W. POHLE, M. D. AND N. W. McKITTRICK, M. D.
Milwaukee

H. W. POHLE

Receiving his degree in medicine from the University of Wisconsin Medical School in 1938, Doctor Pohle interned at Research Hospital in Kansas City, Missouri and then completed a residency in internal medicine at the State of Wisconsin General Hospital. After three years with the Army Medical Corps he returned to a practice of internal medicine in Milwaukee. He is now clinical instructor in medicine at Marquette University School of Medicine and is associated with the staffs of Columbia and Milwaukee County Hospitals.

N. W. McKITTRICK

Doctor McKittrick graduated from Nebraska University School of Medicine in 1932. He served his internship at Columbia Hospital, Milwaukee Children's Hospital, and South View Hospital, Milwaukee, following which he served a two year general residency at Columbia Hospital. Since 1936 he has practiced internal medicine in Milwaukee, where he is on the staffs of Columbia Hospital and Johnston Emergency Hospital.

FROM a clinical standpoint, the accumulation of excessive amounts of intercellular fluid most frequently occurs as the result of one or more of three principal mechanisms: increased intravascular hydrostatic pressure, altered capillary permeability, and disturbed physicochemical equilibrium largely based on altered osmotic pressure values. In the simpler instances, venous and lymphatic obstruction produce edema because of increased hydrostatic pressure. Inflammation, allergic reactions, and heat produce edema because of altered capillary permeability. Elimination of edema in these cases depends upon correction of the underlying cause. In the more complex instances, however, which are largely those due to disturbance of physicochemical equilibrium or a combination of etiologic mechanisms, the elimination of edema is a much more difficult problem.

This complex group occurs most frequently in congestive heart failure and primary renal disease. Each is distinguished by the fact that the underlying mechanism is a complex one, and each presents a peculiar problem to the physician in that the edema makes the primary disease worse. In acute or chronic nephritis, the accumulation of extracellular fluid in the renal tissue further impairs the already overburdened kidney. In congestive heart failure, edema interferes with the transfer of oxygen from alveolus to capillary centrally and again from capillary to tissue cell peripherally. This latter fact is doubly important within the failing heart muscle itself. Add to this the extra load which increased blood volume attending edema implies, and the vicious circle is complete.

Pathologic Physiology

The key to the therapeutic approach of this group lies in an understanding of the basic pathologic physiology involved. In primary renal failure, older teaching implied that glomerulonephritis was a widespread disease of body capillaries. These injured vessels were thought to be abnormally permeable, thus allowing fluid and protein to escape into the extracellular spaces. In reviewing this problem, Warren and Stead[1] measured the protein content of the edema fluid and found that it corresponds very closely to that collected from patients with congestive heart failure. Their observations suggest that the diseased kidney finds itself unable to excrete all the sodium and water brought to it. This excess sodium is stored in the extracellular spaces along with water to maintain osmotic balance. This stored water is derived from the surrounding cells and from the plasma. Cellular dehydration results. When the urinary loss of serum albumin is great, the low serum albumin further exaggerates the process by reducing intravascular osmotic pressure and facilitating the flow of fluid from blood stream to tissue spaces. If this explanation is correct, adequate restriction of sodium intake, removal of stored sodium, and correction of hypoproteinemia if present should clear the edema.

In heart disease it is agreed that when the myocardium begins to fail, a chain of events is initiated which ends in congestive heart failure. The last word of explanation of this sequence of events has not been written, but much fact is known. Some of the older assumptions are no longer acceptable in the light of present knowledge. The time-honored belief in capillary anoxia and subsequent increased permeability becomes untenable because on measurement, protein content of the edema fluid is lower than in edema fluids known to be due to that mechanism.[2] Other states attended by low oxygen tension, such as exposure to high altitude, chronic pulmonary

emphysema, and tetralogy of Fallot are not accompanied by edema. The importance of an increased venous pressure, fundamental in the "backward" theory of heart failure, is open to question in view of the fact that a mediastinal tumor with tremendous venous pressure increase fails to produce edema.[3] Warren and Stead have attempted to prove that in some instances, weight gain, indicating water storage, actually preceded rise in venous pressure.[2]

On the other hand, there have been some convincing demonstrations of the role of sodium in the production of edema. It has been shown that edema and significant rise in venous pressure and blood volume can be produced by feeding large amounts of salt to healthy individuals.[4] Overdose of desoxycorticosterone, by blocking sodium chloride excretion, will produce the entire picture of congestive heart failure without affecting the heart.[5] Finally, it has been shown, by giving sodium chloride parenterally, that the kidney in congestive heart failure is approximately five times less able to excrete sodium than is the normal kidney.[6] These observations point toward the present day feeling that when cardiac output falls, renal clearance of sodium is impaired. This sodium is partly stored in the extracellular spaces and extracts water from the surrounding cells. The excess sodium remaining in the plasma binds water and raises the blood volume, which in turn contributes to the elevation of venous pressure.

If these deductions are correct, rational therapy of congestive heart failure with its attendant edema should then consist of rest and digitalis for the failing myocardium, adequate restriction of sodium intake, and mobilization and removal of the retained sodium. Moreover, it becomes obvious that simple water restriction will accomplish nothing but make the patient thirsty and press cellular dehydration to the danger point.

Therapeutic Approach

Sodium restriction in order to be effective in the average case, must be kept to a daily intake of about 2 gm. as sodium chloride.[7] The average person ingests 8 to 12 gm. per day. If no salt is added after cooking, the intake falls to about 6 gm. per day. If no salt is added in cooking, as in the average hospital salt-poor diet, the salt intake falls to 3 to 4 gm. per day. It is apparent then that a special diet must be devised. This was first accomplished by Newburgh and later modified by Schemm.[8] This diet combines two desirable features. It not only adequately restricts sodium but combines foods in such a manner that the metabolic result is an excess of acids which combine with sodium and take it to the kidney where some is excreted. This last feature is most important because sodium must be kept mobilized if proper water balance is to be maintained.

Two methods of mobilizing and facilitating renal excretion of stored sodium have been in clinical use for many years. The so-called acidifying agents, as, for example, ammonium chloride and dilute hydrochloric acid, are metabolized to liberate excess acid ions in the body. This excess acid ion combines with excess sodium and upon arrival at the kidney finds the kidney unable to manufacture ammonia fast enough to free and turn back the sodium so some of the sodium is excreted in the urine. In addition the mercurial diuretics such as salyrgan, mercuhydrin, and mercupurin block tubular reabsorption of sodium, resulting in further sodium excretion. It is apparent that adequate water must be provided not only to hydrate the thirst body cells, but to provide ample excess so that this renal process can proceed. These two measures have been most efficient in the emergency, but the implied necessity for continued administration of pills and shots makes them undesirable for use over a long period. The Schemm diet, however, will adequately restrict sodium not to exceed the renal ability to excrete it and thus maintain the patient edema free indefinitely.

We have used this diet since it was first suggested by Schemm five years ago. Our experience with it has been so uniformly favorable that we consider it the most important contribution to the management of edema made in this period. It has completely revolutionized our handling of cases with congestive heart failure. Once the edema has been brought under control, the patient usually remains edema-free on the diet alone. The occasional case needs to continue some acidifying agent such as ammonium chloride. On rare occasions it has been necessary to administer further mercurial diuretics. Careful investigation has usually shown, however, that in these instances the patient either has failed to follow directions or has unwittingly ingested sodium as sodium bicarbonate for "gas," etc. Once the physician and patient become familiar with the regimen, it becomes both practical and easy to follow. Emphasis must be constantly placed, however, on the fact that it must be followed religiously, and even minor indiscretions will end in complete failure. In practice, patients have so much appreciated being edema-free without the necessity for repeated "shots" that they have been more than willing to adjust themselves to living without salt.

Much has been written relative to the optimum amount of water that should be administered. It has already been pointed out that water restriction is discomforting, irrational, and dangerous. There are those who maintain that fluids should be forced to a total of 4,000 to 5,000 cc. daily.[8, 9] All writers agree that water in any amount does no harm. Leevy feels that forcing fluids neither hinders nor facilitates the removal of edema fluid in most instances.[10] We have urged all patients to drink liberally but have not forced fluids except where azotemia, infection, or sulfa drug administration have demanded it. We have thus avoided nausea which sometimes accompanies excessive oral water intake, and, as indicated earlier, the response of patients has been most gratifying.

Conclusions

1. The present day management of the edema of congestive heart failure is primarily a problem of sodium control.

2. In addition to specific therapy directed toward the underlying disease, clearing and subsequent control of the edema is based on restriction of sodium intake and mobilization and excretion of stored sodium.

3. The acidifying agents and mercurial diuretics are very useful in the initial clearing of edema but become impractical when used over long periods.

4. The low sodium acid ash diet furnishes an efficient practical means of restricting sodium intake and promoting adequate sodium excretion over long periods.

5. During a five year experience with the low sodium acid ash diet it has rarely been necessary to administer further acidifying agents or mercurial diuretics after edema has once been brought under control.

6. Liberal water intake abolishes thirst, protects against azotemia, and maintains adequate urinary output to insure optimum sodium excretion.

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An Outline of Procedure For Routine Roentgenologic Gastrointestinal Examinations

By C. F. SHERMAN, M. D.

Madison

C. F. SHERMAN

Doctor Sherman graduated from the University of Colorado School of Medicine in 1928 and served a residency in radiology at the University of Chicago, The School of Medicine. A radiologist with the United States Veterans Administration until 1944, he has since been a radiologist at St. Mary's Hospital.

THE subject of this paper was suggested by the program committee, in the interest of the general practitioner who does not have the services of a radiologist readily available. A program will be outlined which the writer feels will furnish a maximum in diagnostic evidence, with a minimum of expense and inconvenience to the patient.

Gallbladder

Most radiologists have adopted the propionic acid contrast medium which is currently available under the trade name of "Priodax" for routine use. It is superior to the phenolphthalein dyes in several respects, i.e., it gives more dense gallbladder shadows, it appears less often in the bowel to cloud the field, and it causes less side reactions such as nausea and diarrhea.[1,2,3]

About the only real contraindication to administration of standard doses of any of the dyes is jaundice. In this, our experience is in agreement with that of Huber,[4] who did the examination in 50 jaundiced patients and concluded that, while not harmful to the patient, the examination is of no differential value and might better be deferred until the icterus subsides.

In the preparation of the patient, we have adopted a greatly simplified technic in preference to some

of the more complicated ones to be found in the literature. Probably the most important point is that a routine method be adopted and adhered to as a minimum, with additional films or procedures used only in exceptional or unusual cases. The packages in which the new contrast medium is supplied contain adequate instructions to the patient. The 6 half-gram tablets are taken with a low-fat evening meal, and the patient takes nothing more by mouth except water until the fat meal is given. The first film is made approximately fourteen hours after the administration of the dye. If this film shows any need for it, either additional posteroanterior or oblique films are made; and then the fat meal is given. We have tried several fat meals, and have concluded that the egg and cream mixtures offer no advantage over the commercial preparations (Cholestim, Cholex, etc.) which are much simpler to prepare. One additional film is made thirty minutes after the administration of the fat meal.

It is oftentimes desirable to combine the gallbladder visualization with either a gastric series or a colon examination, and this can easily be done. We do not make a practice of combining the colon and gastric examinations on the same day because of the conflicting barium shadows.

In order to do any of these examinations with any accuracy, it is felt that equipment must be available so that films can be made using short exposures (high milliampere technic) with the Bucky grid. I have been asked, on occasion, to interpret films of the gallbladder made without a grid. The films are so hazy and fogged by scattered radiation as to be undiagnostic.

Stomach or Gastric Series

Preparation of the patient for a gastric series is simple and consists of his abstinence from food or fluid intake from 8 o'clock in the evening preceding the examination until after the five-hour film has been made. In the selection of a contrast medium, I again favor the commercial preparations, which contain finely ground cereal and barium sulfate. These mixtures are relatively inexpensive; they permit excellent visualization of the rugae; and they stay in suspension, which obviates continual stirring and facilitates evacuation. If plain barium sulfate and water is used, we believe it should contain some agar preparation, preferably one without phenolphthalein.

It is desirable from the patient's standpoint to do the fluoroscopic examination during the morning hours. We have established a routine of beginning at 9:30 a.m. This leaves time to complete the gallbladder series first, if one is done on the same day. Before the flouroscopist begins he should be in possession of the clinical diagnosis and information relative to hemorrhage. In addition, I have made it a practice to take a brief history at the beginning of the fluoroscopy for my own benefit and to distract the patient's attention from the rather somber surroundings of the darkened room.

It is much more desirable to do the fluoroscopy with the patient standing whenever possible. Whether he is to be examined prone and recumbent depends on whether there is any suspicion of diaphragmatic hernia or other pathology in the cardia. In a busy hospital department, I find that taking films of all patients both erect and prone is too time consuming, but if this is not done one must be on guard against missing lesions in the cardia.

At the commencement of the fluoroscopy, while a brief history is being elicited, it is convenient to make a quick survey of the lung fields, heart, and entire abdomen. Pathology outside the gastrointestinal tract, sometimes unsuspected, is frequently picked up in this way. The patient is then instructed to take two liberal swallows from his 6-ounce barium meal. This is followed down the entire length of the esophagus, the fluoroscopist being on the lookout for narrowing, displacement, diverticulum, gastric hernia, etc. Then, before the patient takes any more of the meal, a study is made of the gastric rugae, looking carefully for any distortion, rigidity, or niche, especially on the posterior wall. Rather active manipulation must be used. I refuse to take the responsibility for this examination if it is done sooner than three or four weeks after any known bleeding has ceased. If done before that, I use no manipulation whatever, and for this reason the examination cannot be considered complete.

At this point an attempt is made to fill the duodenal bulb if it has not already filled spontaneously. Then the patient is instructed to swallow the remainder of the barium meal. The stomach is studied in posteroanterior, oblique, and lateral positions, and the entire duodenum is also observed for activity of peristalsis, niche, or filling defects. Following this, further examination should be done in the prone position, the Valsalva maneuver being used if diaphragmatic hernia is suspected.

Two Bucky grid films are made routinely (in addition to whatever spot radiographs may have been made on the fluoroscope). One of these is made in the posteroanterior and one in an extreme right anterior oblique position. After this, the patient is released with instructions not to eat or drink and to return in five hours for a large film of the entire abdomen. It is our practice to take a four or five hour plate routinely; not infrequently a one and/or a two or three hour film is also made. I believe that a five hour film is indispensable. It gives a great deal of evidence, either of pathology or of the absence of pathology. The small bowel can no longer be looked upon as an unchartered void in the middle of the gastrointestinal tract. We have recently discovered 2 cases of unusual interest by means of the five hour film.

Colon

Preparation of the patient for a colon examination consists simply of emptying the colon prior to

administration of the barium enema. It can be done by use of castor oil on the day before, or by giving one or two high cleansing enemas just prior to the barium enema. We permit the attending physician to use whatever he prefers.

The choice of the contrast medium is simple. A mixture which works well is one advocated by Poppel and Bercow[5] consisting of 75.0 gm. of barium sulfate, 5.0 gm. of acacia, and water, as much as will suffice, up to 2 quarts. This mixture shows the markings well and stays in suspension fairly well. We use the same mixture that we use for the barium meal, however, because it is easy to prepare and possesses practically all the advantages of the others. We use a rigid metal enema tip and give the enema fairly rapidly.

As in other gastrointestinal radiography, I feel that in my hands, at least, the fluoroscopy is the most important part of the examination. It should be done fairly rapidly, usually not consuming over two or three minutes unless some obstruction is encountered. When an obstructive filling defect is encountered, one should not attempt to force any more barium past than is necessary for identification. During the fluoroscopy the patient must be rotated into oblique and sometimes lateral positions in order to visualize all of the large bowel. One should try also to fill the terminal ileum. The fluoroscopist must note the configuration or pattern, tenderness or fixation on manipulation, spasm, diverticula, or filling defects. We do not feet that the colon examination is entirely dependable for rectal lesions because no manipulation is possible; for rectal lesions proctoscopic examination is recommended. In cases of obscure bleeding a double contrast enema should be used. This consists of doing the usual barium enema, allowing the patient to expell most of the barium, and then introducing air into the colon under fluoroscopic control to outline papillomata or small infiltrating or ulcerated lesions of the mucosa.

After the enema we make it a practice to take an immediate film of the abdomen while the colon is still filled. Wherever there is any uncertainty after fluoroscopy, a postevacuation film is also made. When a double contrast enema is given, a film is also made with the bowel filled with air. Some clinics do not make films at all, relying entirely on the results of the fluoroscopy. An occasional lesion will be missed this way; I believe the films are worth while as a basis of comparison in possible future progress examinations if for no other reason.

Some patients, usually elderly ones with incompetent rectal sphincters, present a problem. In these cases the bowel can sometimes be filled by using one of the special enema tips which has a soft rubber ball around the neck of the enema tube and can be held tightly against the anal opening by an assistant.

Another method is to have the patient lie prone and pack towels around the enema tip during the administration of the enema. In colostomy cases we find it better to inject the barium into one, or both, colostomy openings by means of an irrigating syringe, rather than using the gravity method.

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AMERICAN ACADEMY OF PEDIATRICS

The areal meeting of the American Academy of Pediatrics will be held at the Hotel Schroeder, Milwaukee, June 28–30, 1948. Members of state medical societies are welcome to attend. The registration fee will be $5.00 for such non-members, together with a $5.00 registration for which each registrant receives a ticket to the banquet, making a total registration fee of $10.00.

Registration may be made ahead of time by writing to Dr. C. G. Grulee, Secretary-Treasurer, American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for $10.00, or registration may be at the time of the meeting.

Generalized Scleroderma

Report of a Case

By ANTHONY N. RIES, M. D.
Evanston, Illinois

A. N. RIES

Doctor Ries received his medical degree from the Karl Franzens University, Graz, Austria in 1937. He interned at St. Mary's Hospital, Philadelphia, and took his postgraduate study in pathology at the University of Minnesota Medical School. He has worked with the United States Public Health Service and the Veterans Administration. Now acting director of laboratory at St. Francis Hospital in Evanston, he formerly was senior resident in pathology at the Milwaukee County Hospital.

SCLERODERMA is a progressive disease that is characterized by induration of the skin, which may by localized or diffuse and frequently associated with atrophy and pigmentation. In certain cases visceral changes, especially gastrointestinal and cardiac, are paramount.

The etiology of scleroderma is still unknown today.[1] Its existence as a skin disease has been known for many years. Alibert[2] made the first observations of scleroderma in 1837, and since then much has been said and written about it. As a rule the onset and progress of the disease is insidious, but it may spread rapidly and involve large areas in a short period of time. It may occur during any period of life and is found to affect the female twice as often as the male.

Clinically, three types may be distinguished: the edematous, the indurative, and the atrophic type. The characteristic feature of the initial edema is that it does not pit on pressure. In the indurative type the skin becomes hardened and stiffened, while the atrophic type reveals the fingers to be thin, pointed, and immobile because of the dermal changes. The skin of the face, neck, trunk, and extremities is often affected. The palm of the hand and sole of the foot are rarely involved. When the face is involved it becomes masklike. Mastication is difficult. All mucous membranes of the mouth may be involved in the indurative and atrophic process.[3] Ulcers, probably due to tension and deficient circulation, develop mainly on the finger tips, the elbows, and the ankles. Joint movement may be impaired; this is due to sclerosis of the tissue about the joint. If the hands are involved the fingers are moved with difficulty or are fixed in a semiflexed position and may become reduced in size. Calcium deposits in soft tissues have often been observed, and true calcinosis in combination with scleroderma has been described. The calcium metabolism is affected so that there is usually an increase of the blood calcium. There is a low calcium content of the urine in patients with scleroderma because of its retention in the soft tissues.[4] The role of the kidney in the entire process is not entirely clear. Decalcification of bone in the terminal phalanges may be shown by roentgen examination.

In the past few years there has been increasing interest in this disease because of the cardiac findings and the x-ray findings in the esophagus and intestinal tract.

The cardiac findings reported in scleroderma are precordial pain, dyspnea on exertion, orthopnea, productive cough, edema of the ankles, cardiac hypertrophy, auricular fibrillation, extrasystoles, pericardial friction rub, apical systolic murmur, and accentuated pulmonic second sound that is louder than the aortic second sound.[5] Electrocardiogram may show left axis deviation, bundle branch block, and auricular fibrillation. The lungs may be affected and reveal a diffuse fibrosis which may or may not cause dyspnea.

Esophageal ulcers with constriction and resultant dysphagia have been described in some cases as an early symptom.[6] Sclerodermic changes in the connective and muscle tissues of the esophagus are chiefly responsible for the esophageal disturbances.[7] Such ulcerations involve the distal one-third of the esophagus. Peristalsis of the gastrointestinal tract may be impaired, giving the roentgenologic appearance of a dilatation of the stomach and intestines. This is due not to actual distention but to the fact that the stomach and intestines do not contract and remain open to full caliber even when not distended by food or fluid.[8]

The characteristic histologic changes in the skin are flattening of the epidermis and rete pegs, homogenization and sclerosis of the connective tissue, atrophy of the dermal appendages, and a mild perivascular lymphocytic infiltration.[9] Degeneration and fragmentation of the elastic fibers and muscle may occur. Scleroderma may affect the connective tissue in almost any part of the body.

Olsen, O'Leary, and Kirklin[7] reported that up to October 1945 a review of the literature revealed a total of 32 reported cases of scleroderma with esophageal lesions. Seven of the patients were male and 25 were female. Of these, 4 were classified as having generalized scleroderma. The results of examination at necropsy were described in 8 cases.

The records of this hospital reveal only 2 cases of scleroderma. One was a 44 year old iceman who was admitted January 9, 1929 and left at his own request January 21, 1929. The second case is that described here in detail with autopsy findings.

Report of Case

A 53 year old white man, a maintenance worker, was admitted to the Milwaukee County Hospital on November 30, 1944. Diagnosis on admission to the hospital was scleroderma.

History.—Five months prior to admission, pain and stiffness were experienced in both knees, hips, elbows, and wrists. At the same time a brownish pigmentation of the skin was noticed over the above named areas and over the face, neck, and dorsal aspect of both hands. The skin felt thick, toughened, and tightly drawn. Other symptoms were marked weakness and anorexia with a loss of 30 pounds in weight over a period of five months. At the onset of this condition, diarrhea occurred during the first four days. Dyspnea on exertion had been noted for five months, and intermittent productive cough for one year. No chills, fever, night sweats, chest pain, or hemoptysis were experienced. Two months after the onset of the symptoms, small areas of ulceration of the skin over the elbows appeared.

Past History.—Past history revealed that he had a rectal abscess incised in 1935 with intermittent drainage thereafter for two years. He was admitted to the Milwaukee County Hospital September 14, 1937 for the treatment of posterior rectal sinus and hypertrophied papillae. There were three subsequent admissions to the hospital—on April 15, 1942, July 13, 1942, and April 13, 1943—for chronic alcoholism. Family history was irrelevant.

Physical Examination on Admission.—A generalized deep brown discoloration of the skin, especially over the elbows, midline of the back, over the sacrum, and in some of the body folds was noted. The skin was tense and shiny, especially over the elbows and ankles. The skin of the face was tan colored and lighter in tone than that of the body. There was a diffuse brownish pigmentation over the trunk anteriorly and over the abdomen, varying in color from tan to brown. There was also a diffuse brownish discoloration of the skin of the arms and the dorsal aspect of the hands, being darker over the elbows and hands. The skin of the forearms and hands was firm, tender, and harder than normal on palpation. The elbow joints could not be extended completely. The fingers of both hands revealed some enlargement of the joints and could not be fully extended. The skin over the legs was light brown with dark brown pigmentation over the knees and feet. The feet were tender on palpation. There was a slight degree of edema of the legs. The ankles revealed some increase of the periarticular tissue. The skin of the external genitalia was very dark. Several grayish brown-colored macules were found over the hard palate and buccal mucosa. The heart was not enlarged. Apex impulse was not palpable. The heart sounds very weak. No thrills, murmurs, or pericardial friction rub were heard. The pulse was barely palpable. Blood pressure was 130/80, respiration 25, and pulse 84.

On December 18, 1944 a biopsy was taken from the dorsal surface, lower third of the right forearm. The skin was extremely tough and about twice the normal thickness. Histopathologic changes in the skin were both diffuse and prominent. The zona basalis of the epidermis exhibited excessive pigmentation, most of which was rather irregular in distribution. Dermal papillae were flattened and obscured. Immediately beneath the epidermis the collagenous tissue was wavy, somewhat granular, and speckled with a grayish cast. On higher magnification minute twisted fragments of elastic tissue were seen in the cleft-like spaces between the acellular connective tissue fibers. The deeper dermal tissues showed a rather marked thickening of the collagenous fibers and their fusion into homogeneous deeply eosinophilic masses. Such changes were continuous into the subcutaneous tissue. The sweat glands were sparse and atrophic.

Therapy consisted of vitamin D, 50,000 units daily, vitamin B complex, pancreatic enzyme 10 drops three times a day, percortin 1 cc. daily, triple bromides, amphojel, prostigmin, and physiotherapy, which consisted of whirlpool bath and massage to both arms and hands.

On March 30, 1945 the patient stated that he felt some improvement of his condition. Objectively the power of flexion at the finger joints and wrists improved from 10 per cent of normal to 40 per cent of normal.

On July 2, 1945 he complained about dyspnea. This began ten days previously and gradually became more severe. There was a moderate productive cough but no chest pain. Breath sounds were coarse on auscultation over the lower lobes of both lungs. There was a generalized brownish pigmentation of the skin. Blood pressure was 156/90, pulse 84, respiration 22, and temperature 98.2 F.

On August 16, 1946 he complained about dyspnea and moderate constriction over the lower third of the sternum and epigastrium. Blood pressure was 170/104.

On August 26, 1946 he became mentally confused and disoriented, and his condition gradually became worse. On September 5, 1946 he became comatose. Respiration was of the Cheyne-Stokes type. The heart had a slow regular gallop quality. Tones were distant. Moist rales and rhonchi were heard over the lung fields.

He died September 5, 1946.

Laboratory Studies Revealed:

White blood cell count	6,150 to 21,350
Hemoglobin	84 to 88%
Neutrophilic polymorphonuclears	47 to 70%
Eosinophils	4%
Basophils	2%
Monocytes	3%
Lymphocytes	14 to 32%

The blood sugar content was 80 mg., creatinine 3.0 mg., cholesterol 186.5 mg., calcium 14.0 mg., sodium chloride 428.0 mg., alkali reserve 44.7, and nonprotein nitrogen 54.5 to 112 mg. Sedimentation rate was 53 in sixty minutes.

Sputum was negative for acid-fast bacilli. Urinalysis on one occasion revealed 3 plus albumin. Blood serology and spinal fluid were negative.

X-ray studies revealed a negative chest.

Gastrointestinal Series.—There was a partial alteration of the mucosal pattern in the lower one-third of the esophagus characteristic of scleroderma changes in this region (fig. 1). The stomach revealed a normal configuration with no abnormal intrinsic or extrinsic pressure defects. The duodenal cap was normally outlined. A six-hour film showed abnormally slow motility of the barium through the stomach and the small bowel with dilatation of some of the loops of the jejunum (fig. 2). The head of the barium column was in the jejunum. The diagnosis was scleroderma changes of the gastrointestinal tract.

Fig. 1.—Esophagitis. Lower one-third of the esophagus.

Fig. 2.—Impaired peristalsis with dilatation of some of the loops of the jejunum.

Barium Enema.—Contrast visualization revealed a normal configuration of the various segments comprising the large bowel, with numerous diverticula scattered throughout the large bowel, especially in the region of the transverse, descending, and sigmoid colon.

Both Hands.—Both hands revealed abnormal soft tissue calcification at the metacarpal, phalangeal, and interphalangeal joints (fig. 3). There were small punched-out areas in the region of these calcifications. The diagnosis was calcinosis circumscripta (scleroderma changes).

An electrocardiogram revealed myocardial changes, marked left axis deviation, and left bundle branch block. An electrocardiogram taken on September 5, 1946, while the patient was dying revealed ventricular fibrillation (fig. 4).

Autopsy

The body was that of a fairly well developed and poorly nourished white man with a body length of 169 cm. and an estimated weight of 125 pounds.

The skin of the face was tan colored. The skin of the trunk, abdomen, and extremities was dry, brownish in color, and on palpation felt tense and thickened. The fingers were not atrophic. The skin of the external genitalia was very dark.

The peritoneal cavity contained no fluid. The liver edge extended 3 cm. below the costal margin in the right midclavicular line and 6 cm. below the xiphoid process in the midline. There were numerous diverticula of the transverse colon, the largest of which measured 3 by 1.5 cm.

The pleural cavities contained no fluid.

Heart.—The transverse diameter of the heart measured 12 cm. at the base. Base to apex it measured 10 cm. The heart weighed 495 gm. The tricuspid valve measured 11 cm. in circumference. The right ventricle measured 4 mm. in thickness. The pulmonary artery measured 7 cm. in circumference and revealed no abnormalties. The mitral valve easily admitted three fingers, measured 10 cm. in circumference, and revealed a slight degree of thickening of the leaflets at the margin. The left ventricle measured 15 mm. in thickness. There was a rounding out of the ventricle at the apex. The aorta above the valve measured 7.5 cm. in circumference and revealed several small scattered grayish yellow atheromatous plaques over the intima. The valve leaflets of the aorta revealed no abnormalties. The myocardium was reddish brown-colored, and over the trabeculae carneae of the left ventricle there was a dull-appearing surface. The coronary arteries were patent and revealed a slight degree of sclerosis.

Lungs.—The left lung weighed 480 gm. The external surface was grayish blue colored. There were numerous emphysematous blebs at the apex and upper lobe and a small area of atelectasis on the lateral margin of the upper lobe. Cut section of the left lung was dark reddish-colored and moist. The right lung weighed 650 gm. The external and cut surfaces were similar to those of the left lung. There were no areas of consolidation in the right or left lung. The mucosa of the bronchi was dark red-colored and moist.

Liver.—The liver weighed 1,600 gm. The external surface was smooth and reddish brown-colored. Cut section was reddish brown-colored with small scattered areas of mottling throughout the parenchyma.

Kidneys.—The left kidney measured 12 by 4.5 by 3 cm. and weighed 120 gm. The capsule stripped

Fig. 3.—Soft tissue calcifications at the metacarpal-phalangeal and interphalangeal joints.

easily, revealing a slightly granular and grayish red-colored external surface. Cut section was grayish red. The cortex measured 6 mm. and the medulla 10 mm. in thickness. The right kidney was similar.

The pancreas and adrenal glands revealed no gross abnormalities.

The prostate gland revealed a slight degree of hypertrophy of the right lobe. It was moderately firm in consistency and revealed a grayish white cut surface.

The thyroid gland was not enlarged and revealed no abnormalities.

Gastrointestinal Tract.—At the distal portion of the esophagus just above the cardiac end of the stomach there were two irregularly shaped superficial areas of ulceration measuring 3 by 1 cm. and 2.5 by 1 cm. The border of these ulcers was dark reddish. The mucosa surrounding these areas of ulceration was grayish blue-colored. The mucosa of the stomach was smooth and revealed no abnormalities. The rugae were present. The stomach wall was of uniform thickness and was uniformly pliable. No grossly demonstrable changes were found in the small bowel.

Head.—The dura mater was roughened at the base of the skull and in the cerebellar fossae revealed a moderate degree of thickening due to infiltration with calcium. The brain weighed 1,285 gm. There was a slight opacity of the pia mater with some flattening of the gyri. The blood vessels within the sulci were somewhat dilated. Cut section of the brain was moist with no gross changes demonstrable.

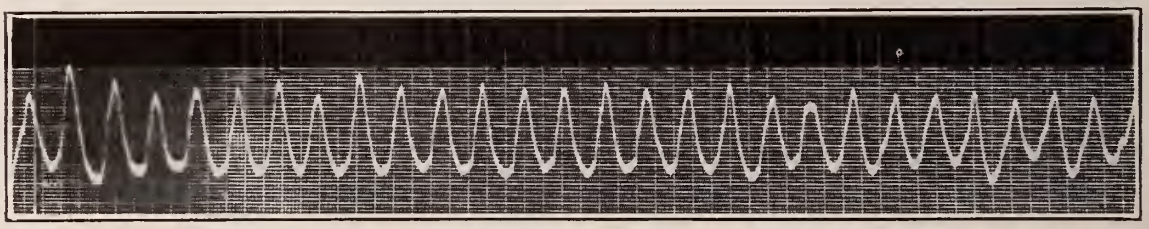

Fig. 4.—Electrocardiogram taken at time of death reveals ventricular fibrillation.

OPPOSITE PAGE

Fig. 5.—Skin of forearm area shows homogenization and sclerosis of the connective tissue in the dermis. x 200.

Fig. 6.—Esophagus. Section at margin of ulceration. Inflammatory reaction and fibrosis are seen to seriously disturb normal histologic relationships. x 200.

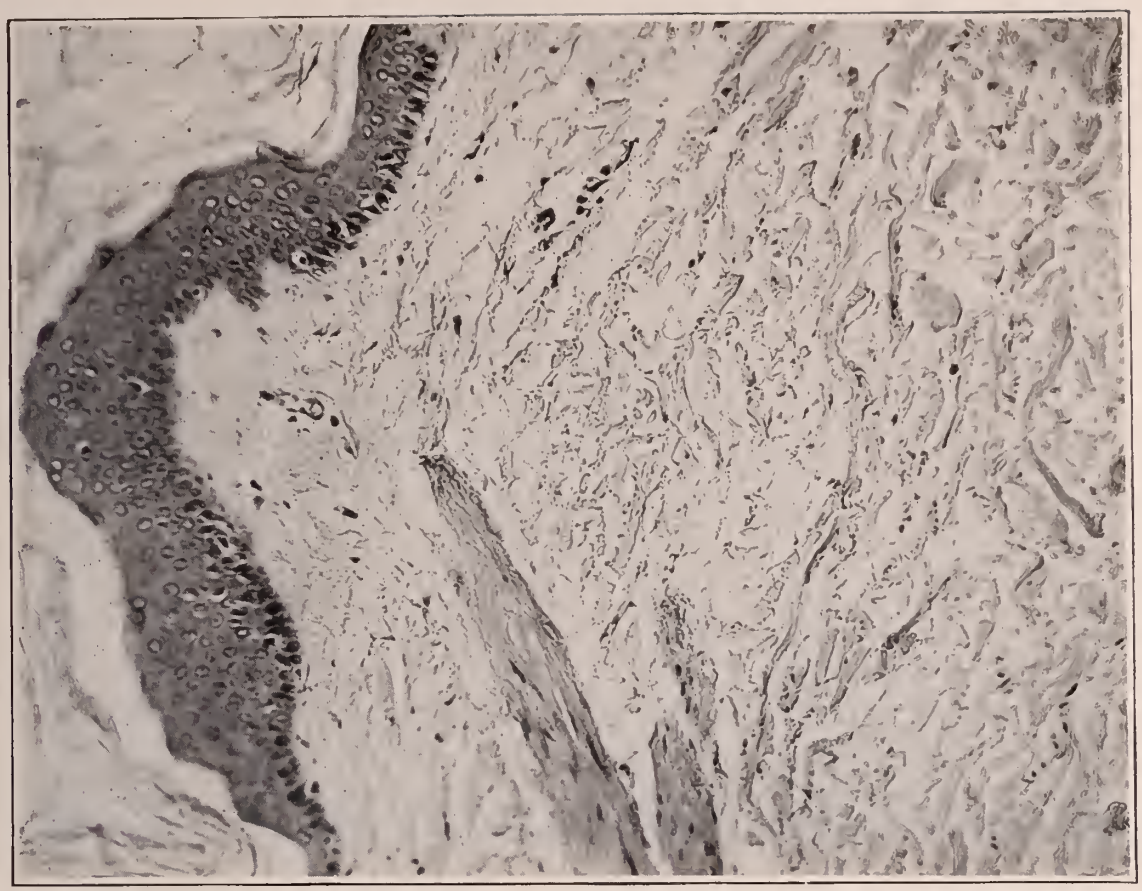

Fig. 5.

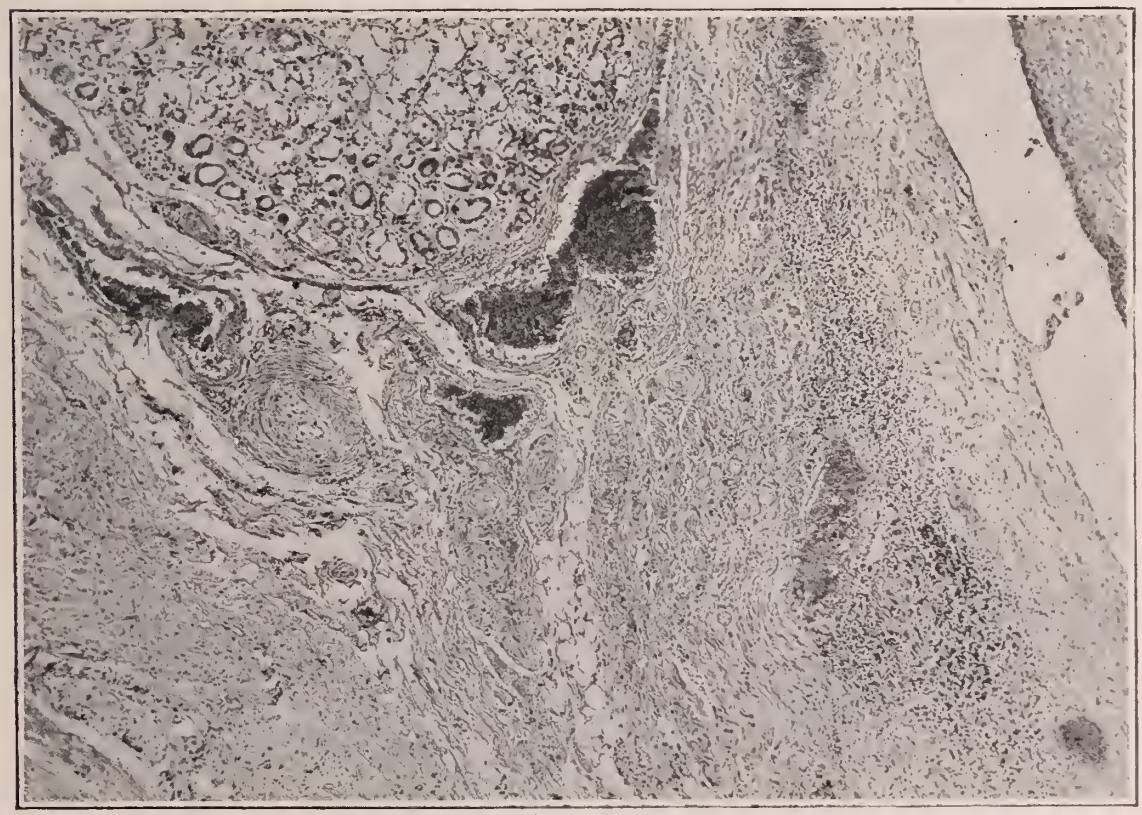

Fig. 6.

Microscopic Examination

Rather startling collagenous changes were observed in the skin, in the gastrointestinal tract, in the myocardium, and to a lesser extent in the pituitary gland. The organs such as thyroid, pancreas, liver, lungs, spleen, brain, and adrenal glands did not reveal any significant changes that might be interpreted as a part of this disease entity. There were degenerative changes and vascular abnormalities that were interpreted purely as a change of age and the accompanying cardiac decompensation.

The skin exhibited considerable flattening of the epidermis and widely separated skin glands. The dermal connective tissue appeared to be quite dense, homogeneous in appearance, and without definite individual fibril-formation (fig. 5). It was deeply stained with eosin with an almost hyaline type of reaction. It was generally acellular. There was a moderate perivascular lymphocytic infiltration associated with some thickening of the vessel walls. This dermal change was continuous with subcutaneous sclerosis and homogenization.

The esophagus (fig. 6) and small intestine (fig. 7) showed changes of rather marked fibrosis involving the submucosa and the muscularis. This was particularly prominent in the internal muscular coats, where large areas showed the replacement of muscle fibers by rather coarse collagenous tissue. In the esophagus this was associated with ulcerations of the epithelium and an inflammatory reaction.

The heart revealed large irregular patches of fibrosis with complete replacement of the myocardial fibers (fig. 8). Much of this was subendocardial in position. Various stages of fibrosis were noted. Some lymphocytic infiltrations, at times located perivascularly, were observed in some of the areas. The definable myocardial fibers were rather broad and exhibited fragmentation and brown degeneration.

The pituitary gland had an irregular interlacing fibrous network associated with a minute area of calcification. This pattern was rather diffiuse but of a delicate nature.

The prostate gland had well defined muscle connective tissue stroma, in which it was apparent that many of the muscle fibers were being replaced by fibrous tissue. The differentiation in some areas between muscle tissue and collagenous tissue was not too sharp.

In the kidney there was moderate interstitial fibrosis with some degenerative tubular changes. Scattered widely throughout the kidneys there were interstitial foci of calcification. These were located in the cortex. Minor changes of swelling were observed in the glomerular tufts. Some lymphocytic infiltrations of the cortex, congestion and hyalinization of the renal vessels were also observed.

Azocarmine, Masson's trichrome, and van Gieson's preparations identified consistently and more clearly the collagenous tissue changes in the above named organs.

Summary

This case demonstrates that generalized scleroderma is a disease that affects not only the skin but also many other organs, for example, the heart, mouth, esophagus, intestine, kidney, and the pituitary and prostate glands. Diffuse scleroderma is almost invariably progressive. In the case presented here there was no pulmonary fibrosis due to scleroderma, but cardiac failure (with myocardial fibrosis) was most prominent.

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OPPOSITE PAGE

Fig. 7.—Intestine. Replacement of some of the muscle fibers by fibrous tissue. This was most pronounced in the inner circular layer. x 200.

Fig. 8.—Myocardium. Large areas of fibrosis accompanied by myocardial fibers exhibiting brown degeneration. x 400.

AMERICAN SOCIETY FOR THE STUDY OF STERILITY

The American Society for the Study of Sterility is holding its fourth annual national session on June 21 and 22, 1948, at the Congress Hotel in Chicago. The two-day program will be divided into a special series of panel discussions on male infertility, with papers to be read on female and miscellaneous infertility aspects on the second day. Additional information may be obtained from the secretary, Dr. John O. Haman, 490 Post Street, San Francisco 2, California.

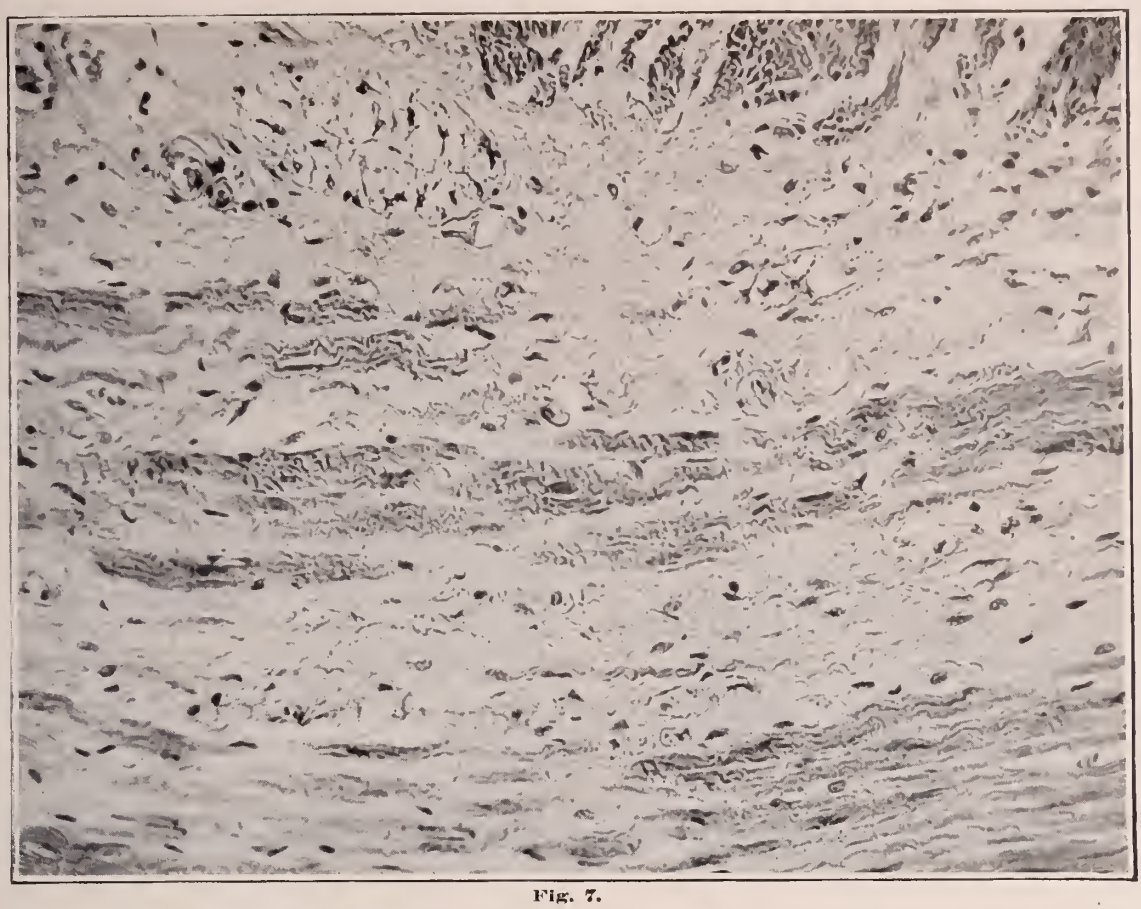

Fig. 7.

Fig. 8.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Therapy of Infectious Hepatitis

Capps and Barker (1947), after systematic study of over 2,000 cases and observation of about 6,000 more, stated that there were only three major therapeutic principles of proved value in infectious hepatitis; these were bed rest, diet, and the avoidance of additional factors injurious to the liver.

Bed Rest

Failure of the patient to go to bed during the acute icteric stage may apparently cause a case of only moderate initial severity to progress to a fatal outcome; in the convalescent stage, after jaundice has disappeared and the physical findings and symptoms have become minimal but full recovery has not yet been achieved, exercise may induce a return of jaundice with a severe and prolonged clinical relapse. Finally, it seems that patients put to bed during the first few days of illness are less likely to develop jaundice than those who remain ambulatory. Capps and Barker said that in their opinion bathroom privileges may be allowed to all who are not seriously ill, but that the bed rest regime should be maintained in all cases until the patient can satisfy the following criteria: (*a*) he shall have had at least three weeks in bed; (*b*) the liver must be neither enlarged nor tender; (*c*) there shall be absence of symptoms, especially lassitude, diarrhea, intestinal cramps, flatus, headache, and anorexia; (*d*) normal serum bilirubin must be present for one week, or, if slightly elevated, the direct Van den Bergh must be negative; (*e*) bromsulfalein must be under 10 per cent in one hour (5 mg. per kg. being the dose) and preferably under 5 per cent. Also, if available, the cephalin cholesterol flocculation test should be 2 plus or less in twenty-four hours and the alkaline serum phosphatase under 4.0 Bodansky units. If only one finding is positive the patient should be kept in bed one extra week. These observers found in military practice that even when the above criteria for return to the ambulatory state are met, about 10 per cent of patients will show an abnormal exercise tolerance test. Patients should therefore be followed carefully for several weeks after returning to work to insure proper convalescence and determine if they have really recovered—failure to return the patient to bed immediately upon recurrence of positive findings might lead to the establishment of chronic hepatitis.

Diet

Capps and Barker felt that while there is ample experimental evidence that a diet high in protein is most desirable for acute liver injury, they do not believe there is sufficient evidence concerning the harmful effects of fat to warrant more than moderate restriction. Wilson *et al.* (1946) compared the progress of 52 patients on a low-fat diet with that of 51 on a high fat diet and found no significant differences in the rate of recovery in the two series. However, Capps and Barker found an excess of fat, other than butter fat, poorly tolerated and in some cases leading to anorexia. They felt that carbohydrates should be high in order to spare protein as well as to provide calories. For the average case they recommended a diet of protein 200 gm., fat 65 gm., and carbohydrates 300 gm. This amount of protein is readily obtained by the liberal use of skimmed milk powder and cottage cheese, and enough fat in the form of butter and cream must be employed to make the diet palatable. For the record, however, it should be stated that Darmady (1945) failed to demonstrate the superiority of a high protein-high vitamin B complex diet in a small but well controlled study. Richardson and Suffern (1945) gave 1.5 gm. of choline chloride as a supplement to a low fat-high carbohydrate diet with the addition of vitamins to alternate cases in a series of 32 patients; no significant benefit of the special diet was observed. Wilson *et al.* (1945) also failed in a controlled series of patients treated with methionine. But in a series of 52 patients to whom they gave 5 gm. of cysteine daily by mouth there was produced what seemed to be a significant shortening of the period of recovery compared with 51 control cases not so treated; it seemed that the recovery occurred sooner because of a smaller number of relapses in the treated group. Capps and Barker (1947) said the addition of neither methionine nor choline produced clearcut results in their experience.

Avoidance of Additional Liver Trauma

In the opinion of Capps and Barker (1947), the most common causes of additional trauma are surgical operations, secondary infections, and exposure to various toxic substances, notably alcohol. They felt that surgical operations are probably injurious because of both tissue trauma and the anesthetic; in cases of emergency, local or spinal anesthesia should be employed, ether, chloroform, and possibly ethylene being likely the most dangerous anesthetics. Secondary infections of all sorts may have a deleterious effect in infectious hepatitis, these patients

(Continued on page 316)

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Cephalin-Cholesterol Flocculation Test, the Thymol Turbidity Test, and the Thymol Flocculation Test

Within the last several years the medical literature has given a good deal of prominence to the use of Hanger's cephalin-cholesterol flocculation test[1, 2] and to Maclagan's thymol turbidity test[3] in the study of hepatocellular dysfunction.

In a previous communication the following points were emphasized in regard to the cephalin-cholesterol test:

1. That a careful study of the procedure by Pohle and Stewart[5] as well as others[6] seems to have confirmed its reliability as an empiric test of active liver damage, but has indicated that it is not a reliable guide for the differentiation of hepatogenous from obstructive jaundice.

2. That the actual mechanism of the test is not clearly understood, although it is considered likely that an increase in serum gamma globulins over the normal[7] or some alteration in the serum gamma globulins from the normal results in the flocculation of the cephalin-cholesterol preparation.

While trying to inhibit an annoying growth of mold in the barbital buffer solution (p^H 7.8) being used in studies with colloidal gold preparations, Maclagan discovered that a crystal of thymol added to the buffer resulted in a solution which produced a turbidity or precipitate with sera from patients with parenchymatous liver disease.[3] It soon became evident to him that there was a close correlation between thymol turbidity and positive gold reactions in patients with altered serum globulins. Many other compounds related to thymol were then tested for their ability to produce a difference in turbidity when added to normal and to hepatitis sera at p^H 7.8. A positive effect was shown principally by phenol and its substitution products, although none of the substances was superior to thymol. Thymol was shown to hold a definite advantage over phenol and the cresols, because it was less likely to give turbidities with sera from cases of obstructive jaundice.

Early work suggested that the cephalin-cholesterol and the thymol turbidity test measured the same serum protein change and could be used interchangeably, but as more reports appeared in the literature, it became obvious that they did not give parallel results in all instances. Recent studies by Cohen and Thompson,[8] laboratory physiologic chemistry, University of Wisconsin Medical School, using eclectrophoretic and ultracentrifuge methods, strongly indicate that beta globulins rather than gamma globulins are involved in the production of a positive thymol turbidity test.

The following points concerning the thymol turbidity test are worthy of note:

1. It is simple and rapid.
2. The reagents are inexpensive and stable.
3. It lends itself to a wider reading scale and, therefore, offers more diagnostically and prognostically than the limited range of readings (0, 1 plus, 2 plus, 3 plus, and 4 plus) of the cephalin-cholesterol test.[9]
4. It seems to be more uniformly negative in biliary tract and hepatic cancer with and without jaundice than the cephalin-cholesterol flocculation test.[10]
5. It is less likely to be positive in cases of cirrhosis or subacute atrophy than the cephalin-cholesterol test.[10]
6. *The Thymol Flocculation Test.*—Eighteen hours after the thymol turbidity reading a flocculation often occurs and can be read like a cephalin-cholesterol flocculation test.[11]
7. The cephalin-cholesterol flocculation, the thymol turbidity, and the thymol flocculation tests have given interesting and important information in cases of infectious hepatitis and especially in the chronic nonicteric form of the disease which can be responsible for continued incapacitating symptoms for many months.[11, 12, 13]
   a. The tests are generally negative during the incubation period.
   b. The cephalin-cholesterol flocculation becomes positive earlier than the thymol turbidity test in the active icteric phase of the disease.
   c. In convalescence and especially in the chronic nonicteric form most of the hepatic tests in common use may be negative. *In some cases, however, the thymol turbidity test and especially the thymol flocculation test have been positive some months after the others have been negative.* Liver biopsies done at this time have indicated a normal parenchyma, but a persistence in the portal triads of lymphocytes, plasma cells, and histiocytes.

Positive cephalin-cholesterol, thymol turbidity, and thymol flocculation tests may occur as a result of serum protein alterations in a variety of conditions *without* primary or secondary liver changes. It is important to remember, therefore, that the proper interpretation of results demands careful consideration of history, physical findings, and other diagnostic tests.[11]

(To be concluded, with references, next month)

As It Looks From the Committee on Nursing Problems of the American Medical Association

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

T. P. MURDOCK

The author of this month's As It Looks From, Dr. Thomas P. Murdock, is the chairman of the Committee on Nursing Problems of the American Medical Association. A graduate of the University of Maryland School of Medicine in 1910, he is president of the Connecticut Board of Medical Examiners and chairman of the council of the Connecticut State Medical Society.

The Nursing Problem

The nursing problem is probably the most serious problem confronting American medicine today. Hospital administrators have found it almost impossible to staff their institutions adequately. Doctors have found it next to impossible to get nurses to care for their very sick patients. Nurses have complained of the heavy load that they have been carrying. All of this due to the shortage of nurses.

All interested agree that there is a shortage. The degree and causes of the shortage are being debated. Nurse executives insist that the shortage is somewhat due to the assignment to nurses of duties which rightfully belong to others, to the large increase in hospital admission, and to the increase in popularity of hospital and medical prepayment plans. Doctors and hospital administrators have been critical of nurses for their unwillingness to change their method of training nurses, to their over-education of the nurse, and their insistence of shorter hours.

Estimates show that in 1910 there was one nurse for each 1,116 people in the United States; in 1940, one nurse for each 316 people. In 1940 there were 38,000 students admitted to nursing schools; in 1944, 67,000. This increase, of course, was due to the cadet program. However, in 1946 the number dropped to 30,899. This is dangerous.

The United States Department of Labor recently issued a bulletin that is both startling and alarming. They estimate that in 1960 approximately 550,000 nurses will be required to care adequately for the American people. At present there are about 317,800 nurses available. This means that the number will have to be doubled in 1960. To accomplish this, about 45,000 to 50,000 nurses must be graduated each year between 1951 and 1960. This is a big contract.

In the argument, as to the degree and causes of the shortage, perhaps both sides are somewhat right. I think it can be accepted that many of the duties now assigned to the nurse are improperly placed and rightfully belong to auxiliary workers. Many of the routine duties of the nurse could be done by a grade of nurse not as highly trained.

It will probably be necessary to elevate the standards of the professional nurses and to place her in the position of nurse educator. At the same time it probably will be advisable to lower the requirements, length of training, and responsibilities of the bedside nurse. In this way you have nurse educator and bedside nurse to care for the sick.

The economic situation must also be corrected. At the present time the average pay of the nurses is between $170 and $180 a month. When one considers training which is comparable,—at least in time,—to three years of college work, all must admit that they are underpaid. Nurses do not come under the Social Security Act. Very few have been provided and very few have accepted retirement funds.

This is a problem that cannot be solved by any one group. A permanent conference committee has been formed made up of representatives of the American Hospital Association, the American Nurses Association, and the American Medical Association. It is the plan of this committee to attack the problems common to all. The first of these is the nursing problem.

A committee of the American Medical Association has been studying this problem since July 1947. The study is nearing completion. As the result of a progress report made to the House of Delegates in January 1948, five representatives were appointed to represent the Association on the permanent conference committee.

These three great bodies—the American Nurses Association, the American Hospital Association, and the American Medical Association—are determined that this serious problem must be solved so that never again will American medicine find itself in this position.—THOMAS P. MURDOCK, M. D.

. . . . THE PRESIDENT'S PAGE . . . .

A Dinner and a Greeting to Dr. C. A. Harper Upon His Retirement From Public Office

IT IS a very special privilege and an honor for me to speak on this occasion for the medical profession of our state.

Doctor Harper: I bring greetings, salutations, and best wishes from conferees, associates, and friends who have observed through the years your artful practice of the science of public health; *artful,* because it is an art to obtain over the long period which you served in the capacity of state health officer the cooperation of the public and the profession in the application of sciences which at times not only denied to both of them privileges which they desired but inflicted denials which they would have preferred to avoid; the *science* of public health, because you sagaciously discerned among all the mass of developing science that which could be effectively applied for the prevention of disease and the promotion of health.

If science is the product of critical observation and accurate reasoning for the selection of that which is true from that which is false, certainly the development of public health legislation and its administration under your leadership exquisitely demonstrates the scientific nature of your administration.

If social science is the development of methods out of the technics of physical science for the promotion of human welfare, then certainly you have contributed largely to the growth of this new science, social science.

If public relations is the creation of personal relations which generate a feeling of cordiality and confidence between one's self and each of the many individuals who compose the public, then your service in public office has exemplified the effectiveness of this spontaneous and sincere quality of your personality.

We have been fortunate to have as our leader one who not only perceived the possibility of applying the developments of science to the control of disease but also had the courage to make the application.

The medical profession of your state has honored you on previous occasions; in 1930 when you received the council award for meritorious and distinguished service, and in 1931 when you were elected president of our State Medical Society. When the president of the Council conferred the award he said:

"CORNELIUS ALLEN HARPER

A son of Wisconsin, a practicing physician since 1894, appointed to the State Board of Health in 1904 by Governor La Follette and serving continuously since with re-appointments from Governors Davidson, Philipp, Blaine and Kohler; for your twenty-nine years of membership on that Board, twenty-seven years as secretary, for your clear vision, for your careful and untiring work in the interest of all people as Health Officer of this State, and for your service as a councilor, and officer of your State Medical Society, we, your fellow members, give you this seal of our Society as a token of your achievements and our esteem and affection.

We again express our affection for you and our thanks for your long period of inspiring leadership."

W. D. Stovall

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« « « EDITORIAL » » »

Introducing the Guest Editorialist

To have the temerity to follow in the late Dr. Eben J. Carey's footsteps would seem too bold and audacious for the great multitude of physicians in Wisconsin, or anywhere for that matter, but it has been done with quiet thoroughness and remarkable success by Dr. John Stephen Hirschboeck. At the time of his selection as Dean of the Marquette University School of Medicine in September 1947, John Hirschboeck was 37 years old, and quite fresh out of the Navy of these United States, after a considerable sojourn on the Island of Guam.

The choice of Doctor Hirschboeck has been an exceedingly salubrious one for Marquette University, as well as organized medicine in Wisconsin, and he will contribute much to the continued growth and academic recognition of his medical school. He works quietly and efficiently, but with hypermetropic foresight and keen insight. He is as successful in the capacity of administrator and executive as he has been as teacher and medical practitioner. Doctor Hirschboeck is making a thorough study of his medical school's curriculum and streamlining some of the rougher areas of instruction. At the same time he is developing a strong cohesiveness within the faculty. He has projected long range plans for a building program at Marquette, and has established a new faculty associateship.

Doctor Hirschboeck is a graduate from Marquette University School of Medicine in 1937, and he has been intimately associated with the practice of medicine and medical problems in Milwaukee and Milwaukee County for a number of years. His professional interest lies in the field of internal medicine, and more specifically in hematology. In addition to his other academic medical affiliations he is a diplomate of the American Board of Internal Medicine. Besides his medical degree, he holds the degree of Master of Medical Science. His fundamental interest as a medical teacher and university administrator is to create a curriculum and maintain a faculty which will be flexible and adaptable to the preparation of the physician of the future, because he knows it can be done, without relinquishing the principles upon which all human relations are based. John Stephen Hirschboeck can do it!—L. R. Cole, M. D.

Physician Shortage and Medical Care

THE shortage of physicians and its corollary, the inadequacy of national medical care, have become watchwords for certain political groups and certain segments of the press. The profession is criticized for monopolizing and inhibiting the expansion of medical schools, thereby assuring an artificial shortage of physicians. The great number of students turned away from the doors of medical schools each year seems to corroborate this complaint.

Is there a shortage of physicians? Is national medical care inadequate? Certain rural areas of the nation are almost entirely served by osteopaths and chiropractors acting as country doctors. Mental hospitals and public health agencies are critically understaffed in most states. The Army, the Navy, and the Veterans Administration are searching for physicians. The eyes of the public turn to the profession for its answer to these questions.

The organized profession has been willing to accept the responsibility for maintaining its own professional and educational standards. It has done the job well. It must also be willing to help establish the social norms of adequate medical care. The organized profession has been reluctant to accept this responsibility and has, at the same time, criticized non-medical and governmental medical groups for attempting to establish these standards. We have worked too much with plans and details without first making a thorough study of the present medical needs of our society and their current fulfillment. If the organized profession will fully accept this challenge and handle it not emotionally and egocentrically but objectively and scientifically, a sound evaluation of medical needs and the methods for fulfilling them will result.

Only after a thorough investigation is made by the profession itself will we be in a position to answer our critics well. Without such a sound analysis all of our explanations and plans will continue to pass as subterfuge in the minds of the critics. What we have done along these lines in the past has not met the challenge.

We as individual physicians know best what our patient needs. Similarly, as a group we are the best qualified to say what the medical needs of the nation are. The profession itself must take the lead in attacking the sociomedical problems of the nation, or else we are doomed to servitude to politicians and bureaucrats.

John S. Hirschboeck, M. D.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

E. S. CAMERON

A 1934 graduate of Johns Hopkins University School of Medicine, Doctor Cameron served there in pediatrics and psychiatry as staff member of the Children's Psychiatric Clinic. She joined the Wisconsin State Department of Health in 1940, serving as pediatrician. Since 1941 she has been the director of mental health of the Department.

Preventive Psychiatry in Wisconsin Communities

The Mental Health Program of the Wisconsin Department of Health was organized in 1941 as part of the Bureau of Maternal and Child Health. It has carried on an educational program in preventive psychiatry and has promoted the establishment of local community psychiatric services for the study and treatment of children with personality disorders of all types. The National Mental Health Act of 1946 authorized the United States Public Health Service to extend its activities into the area of mental health. Monies were made available in 1947 so that now the services of the mental health program of the Wisconsin State Department of Health can be expanded to reach persons of any age.

The program has a central staff consisting of a director, who is a psychiatrist responsible to the State Health Officer, and a supervisor of clinical psychology. A supervisor of psychiatric social work will be added. This staff establishes, directs, and supervises the educational and clinical work in the communities where it promotes programs. Consultation and advisory services are given on request. It is also responsible for the other state-wide activities in mental health which are conducted by the Department of Health. Additional personnel is employed to be used in the local centers on a demonstration basis.

Establishing Community Units

The usual procedure is to lend a psychiatrist to a county for a period of two or three years, after which time the community is expected to assume responsibility for the services. When this is accomplished the department demonstrates the services of a clinical psychologist who cooperates with the locally employed psychiatrist. When the psychologist has been taken over locally, the department then lends the services of a psychiatric social worker under the same conditions,—in this way completing the standard three-member team of a mental hygiene clinic.

Until the total clinic personnel is established as a complete unit, the local professional workers do a great deal of the preparatory work for the individual studies. They also carry the responsibility for implementing the environmental therapy recommended. The clinic staffs do all of the individual psychotherapy. Throughout the demonstration periods the staffs interpret the use of the services, the kinds of cases suitable for referral. They discuss the needs of the patients seen, as well as the needs of people in general, and the ways in which the community can help prevent emotional disturbances.

The demonstrations are usually sponsored by a local group made up of representatives of all organizations in the community which are interested in health and welfare. The county medical society participates in the community planning through its representative. The medical men of the county individually use the services to refer patients who need such study, either on a consultation basis or for treatment, as they see fit.

Early Care The Watchword

The program is primarily a preventive one. Clinic services are available to all persons who exhibit beginning disturbances. The patient is first examined by his own physician and a report of findings sent to the center so all organic factors may be known. Evaluation of assets and liabilities in intelligence, performance, interests, and attitudes is made by psychologic examination. A study of social and economic background, neighborhood and community influences is made by the social worker.

The psychiatrist sees the family and the patient, separately, in order to understand the emotional relationships and the conflicts which have led to the symptoms shown. These symptoms may be psychosomatic difficulties, antisocial acts, neurotic behavior, or any other behavior disorder. They all indicate the need for help with the personal problem. After the study is completed and diagnosis is made, recommendations for treatment, whether environmental or individual, are made.

Activities at the State Level

In addition to the direct service given to individuals and the aid to communities in establishing needed facilities a state-wide educational program is conducted. Through literature of all types, radio talks, and a library of films which can be used by

(Continued on page 316)

Tumor Clinic Opens at the State of Wisconsin General Hospital, March 15, 1948

By A. R. CURRERI, M. D. and B. J. LONGLEY, M. D.
Madison

THE National Cancer Institute has recently appropriated funds to the University of Wisconsin and the State of Wisconsin General Hospital for the establishment of a cancer program to be directed by Drs. A. R. Curreri and B. J. Longley. This program will be approached from three directions, namely: (1) creation of a diagnostic tumor clinic with enlargement and revision of the present follow-up system, (2) integration of clinical material at the University Hospital, (3) coordination of the various departments and facilities of the University and the Hospital for undergraduate and postgraduate teaching of neoplastic diseases.

The immediate and direct benefits to be derived by the physicians of this state through this outlined program are centered about the diagnostic consultation service and postgraduate medical education.

Obviously, the limited personnel and space would neither permit nor warrant the admission to this clinic of all patients with suspicious neoplastic lesions. Furthermore, experience and study have shown that all areas of the state are well provided with trained physicians and hospital facilities to care adequately for most tumors. Only cases which in the opinion of their physician require special study should be sent to this clinic. It will, therefore, be necessary for all patients to have a letter of reference from their physician for admission to the clinic. Unless the referring physician specifically requests treatment, it will be assumed that diagnosis and recommendations for therapy are all that are desired. *The patient will be instructed to return to his physician, who will receive an early report of the study.*

The charges for the patients attending the diagnostic clinic will be $1.00 for a county patient, $5.00 for a special rate patient, and $10.00 for a private patient. These charges cover routine blood count, urinalysis, an x-ray of the chest, Papanicolaou stains, and consultation. Additional charges will be made for special studies or x-rays other than that of the chest. It is obvious that the diagnostic clinic is to be a service to the physicians and the people of the state. These charges will cover only the cost of the Tumor Clinic, and no attending man or consultant will receive financial remuneration for this service. There will be no charges for the patients attending the follow-up clinic, except for special examinations as stated above.

All patients treated for malignant lesions at the State of Wisconsin General Hospital will be requested to return to the follow-up clinic for progress study and possible further therapy. The follow-up clinic will be attended by men from all departments interested in the progress and care of the patient. Thus, there will always be a clinician, a radiologist, and a pathologist present. More efficient and far better treatment for the patient and more effective postgraduate teaching will be possible if certain days of each week of the month are allocated to lesions of the various systems of the body, *i.e.*, patients with lesions of the respiratory system will return the first Friday afternoon of each month; those with postoperative breast lesions will return the third Wednesday afternoon of each month, etc. Such a system of date allocation will assure the visiting physician that he will see a number of similar cases by visiting these clinics at the specified time on the schedule.

The consolidation, coordination, integration, and enlargement of our clinical facilities, combined with the potentialities of the McArdle Memorial Laboratory, will provide excellent material for short intensive postgraduate courses in neoplastic diseases. These courses should prove of interest to all Wisconsin physicians.

All inquiries about the cancer program and patients should be addressed to the Tumor Clinic, Wisconsin General Hospital, Madison 6, Wisconsin.

Monday through Friday

DIAGNOSTIC CLINIC—MORNINGS; FOLLOW-UP CLINICS—AFTERNOONS

Week of Month	DAY OF WEEK					
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	Eye Gastro-intestinal	Gynecology	Conference 2:30 p.m.	Ear, nose, and throat Genitourinary*	Neurology* Chemosurgery Conference 3:30 p.m.	
2	Bone Breast	Gynecology	Conference 2:30 p.m.	Medicine	Chemosurgery Conference 3:30 p.m.	
3	Gastro-intestinal	Gynecology	Conference 2:30 p.m.	Ear, nose, and throat Genitourinary* Medicine	Neurology* Chemosurgery Conference 3:30 p.m.	
4	Bone Breast	Gynecology	Conference 2:30 p.m.	Medicine	Chemosurgery Conference 3:30 p.m.	

*To be held mornings.
The eye and the ear, nose, and throat clinics will be located in the established clinics on the fifth floor of the State of Wisconsin General Hospital.
The genitourinary clinic will be located on 5 North of the State of Wisconsin General Hospital. Monthly Conference: First Wednesday of each month, at 12:15 p.m.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Second Annual Cancer Symposium of the Medical Society of Milwaukee County

Sponsored by the Milwaukee Division of the American Cancer Society, April 8 and 9

Thursday, April 8

7:00–8:00 p. m.

Milwaukee Cancer Detection Center, 545 North Fifteenth Street

Demonstration of regular clinic routine under the direction of **Dr. Joseph Gramling, Jr.**

8:00 p. m.

Marquette University School of Medicine Auditorium

Moderator: **John S. Hirschboeck, M. D.**, dean of the Marquette University School of Medicine

"Management of the Late Cancer Patient"

Surgical viewpoint — **Everett D. Sugarbaker, M. D.**, Ellis Fischel State Cancer Hospital, Columbia, Missouri

Radiologic viewpoint—**T. J. Wachowski, M. D.**, assistant professor of radiology, University of Illinois College of Medicine

General practitioner's viewpoint—**W. B. Harm, M. D.**, secretary of the Section on the General Practice of Medicine, American Medical Association

Friday, April 9

9:00 a. m.

Milwaukee County Hospital

Tumor Clinic group meeting

Patients having the types of cancer to be discussed in the afternoon will be presented for discussion of diagnosis, prognosis, and treatment by the tumor board, staff, and guests. The guest speakers have been invited to participate in this program.

Tumor Board

(Teaching affiliations listed refer to the Marquette University School of Medicine)

Surgeon: **Joseph M. King, M. D.**, surgical director of the Milwaukee County Hospital and associate professor of surgery

Pathologist: **Joseph F. Kuzma, M. D.**, director of laboratory, Milwaukee County Hospital, and assistant professor of pathology

Radiologist: **Jerome Marks, M. D.**, director of x-ray department, Milwaukee County Hospital, and instructor in radiology

Executive Officer: **James G. Garland, M. D.**, assistant professor of surgery

Secretary: **T. J. Pendergast, M. D.**, instructor in surgery

Discussants

Internist: **Francis D. Murphy, M. D.**, medical director of the Milwaukee County Hospital and professor of medicine

Cytologist: **L. J. Van Hecke, M. D.**, assistant professor of pathology

Hematologists: **F. W. Madison, M. D.**, associate professor of medicine, and **John S. Hirschboeck, M. D.**, dean of the Marquette University School of Medicine

Surgeons: **F. A. Stratton, M. D.**, professor of surgery; **Conde Conroy, M. D.**, associate professor of surgery; **Forrester Raine, M. D.**, associate professor of surgery; **J. M. Sullivan, M. D.**, instructor in surgery; **V. B. Hyslop, M. D.**, section of oral surgery, Milwaukee County Hospital

Gynecologist: **R. S. Cron, M. D.**, professor of obstetrics and gynecology

Dermatologists: **M. J. Reuter, M. D.**, assistant professor of dermatology; **H. J. Farrell, M. D.**, assistant professor of dermatology

Leo Massopust, director of the department of art and photography, Marquette University

12:00–1:00 p. m.

Luncheon served at the Milwaukee County Hospital

1:30–2:00 p. m. and following afternoon session

Display at the Marquette University School of Medicine

I. Gross Pathology of Colon and Breast (Cancer Study Museum)

W. A. D. Anderson, M. D., professor of pathology, Marquette University School of Medicine

II. Anatomy of Colon and Rectum

Walter Zeit, Ph. D., professor of anatomy, Marquette University School of Medicine

2:00 p. m.

Marquette University School of Medicine Auditorium

Moderator: **Carl W. Eberbach, M. D.**, associate professor of surgery, Marquette University School of Medicine

"Practical Fundamentals of the Nevi and Melanoma Problem"

Arthur C. Allen, M. D., assistant pathologist, Memorial Hospital, New York

"Lip and Mouth Cancers"

J. Barrett Brown, M. D., associate professor of surgery, Washington University School of Medicine, St. Louis, Missouri

"When Does Jaundice Mean Cancer?"

Leon Schiff, M. D., associate professor of medicine, University of Cincinnati College of Medicine

(Continued on page 315)

The
MEDICAL FORUM

The Wisconsin Medical Journal — March, 1948

DOCTORS AND LAWYERS SEEK IMPROVEMENT OF EXPERT TESTIMONY

County Medical Societies Asked to Solve Problem of Night Calls

Chicago, Mar. 5—The American Medical Association has called on county medical societies to meet the public demand for emergency medical service at night.

From many sections of the United States, says an editorial in the March 6 issue of the Journal of the American Medical Association, complaints have come that persons who have called physicians late at night have been unable to secure attendance from those whom they considered their family physicians.

The AMA says that large county medical societies or urban groups should maintain a physicians' telephone exchange which would take the responsibility for locating physicians if response is not made to the ringing of the telephone in the home or office.

The solution is simple and practical, requiring only a minimum of community organization, states the AMA. Medical societies in the District of Columbia, Milwaukee, and Oakland, Cal., already maintain such exchanges. The exchange can be used at night or on holidays by furnishing the exchange with a list of doctors who are willing to make night calls. If such a roster was publicized, night calls for medical service would soon gravitate to this center and the patient would be assured the services of a physician, the editorial states.

ON THE INSIDE

Subject	Page
Anesthesiologists	2
British Health Act	5
Capitol Views	8
Clark Against Compulsion	8
Funds for Hospitals	4
Industrial Health	7
National Health Assembly	5
Prepayment Plans	2
Press Comments	3
VA Procedures	6
Wisconsin Physicians Service	6
WVMSA Pointers	8

DON'T BE AN OSTRICH

If you bury your nose in anything, bury it in "The National Health and S. 545", a surprisingly well-written 11-page booklet put out by the Research Council for Economic Security.

Contents: What is the national health? Why doesn't everyone get adequate medical care? Is anything being done to help the situation? A comparison of the Taft bill (S. 545) and the Wagner–Murray–Dingell bill (S. 1320). Get your copy by dropping a postcard to the State Medical Society, 917 Tenney Building, Madison 3, Wisconsin.

Few problems in the field of medical service have aroused so much public discussion, the AMA said. Whether resentment against physicians is justified or not, it does harm. The solution for this problem is so eminently simple and would reflect so favorably upon physician-patient relationships that medical societies everywhere are urged to give it serious consideration immediately, the AMA wrote.

The editorial pointed out that actually relatively few "night calls" are so urgent that harm would result from postponing response until morning, but the patient is "little interested in explanations as to the percentage of calls that are not emergencies."

Scheele Surgeon General; Parran to Leave April 6

Dr. Leonard A. Scheele, director of the National Cancer Institute, Bethesda, Md., and a member of the board of directors of the American Cancer Society, has been named surgeon general of the United States Public Health Service.

President Truman recently announced Scheele's appointment as successor to Dr. Thomas Parran who retires April 6.

Will Cooperate in Study of Minnesota Plan; Hope to Stop Flimsy Evidence

Madison, Mar. 2—Plans of the medical profession to cooperate with the State Bar association in efforts to assure the presentation of authentic, expert medical testimony have been announced by Dr. W. D. Stovall, Madison, president of the State Medical Society.

A proposal to eliminate questionable testimony was made by Oscar Toebaas, Madison attorney, in a paper read before the state bar group in Milwaukee recently. Toebaas declared that wide differences of opinion in doctors' testimony sometimes confuse juries and incur public ridicule. He said it was caused by the doctor who becomes "an advocate" and the doctor "who is swayed by the amount of witness fees."

Dr. Stovall said the entire subject has been referred to a committee of the State Medical society composed of Drs. J. W. Prentice, Ashland; Arthur G. Sullivan, Madison, and Elwood W. Mason, Milwaukee. "This committee will be asked to study the Minnesota plan of reviewing testimony presented by expert witnesses and to develop means of cooperation with the attorneys," Dr. Stovall said.

Pointing out that medical practice is not an exact science, Dr. Stovall said, "differences of opinion between doctors on the witness stand do not mean that the doctors are dishonest. Differing testimony may result from honest differences of opinion, and the client's right to these opinions should be protected."

"Above all, the Medical society wants assurance that the right of litigants before courts and commissions are properly protected. The whole objective is to assure justice and not to curtail the rights of those involved as parties to a lawsuit," concluded Dr. Stovall.

(Continued on page 3)

State Board of Medical Examiners as they appeared at the last meeting of the board in January. Left to right, front—Drs. A. F. Rufflo, Kenosha; C. A. Dawson, secretary, River Falls; H. H. Christofferson, president, Colby; back—A. G. Koehler, Oshkosh; E. C. Murphy, Eau Claire; J. W. Prentice, Ashland; E. W. Miller, Milwaukee, and J. W. Smith, Milwaukee.

Name Committees to Study Social Security Problems for Chamber of Commerce

Madison—Six sub-committees within the Social Security Committee of the State Chamber of Commerce have been named to handle recommendations in specific fields of the committee's work.

J. L. Whittet, assistant controller of Ed. Schuster and Company, Milwaukee, and chairman of the social security committee appointed sub-committee chairman as follows:

Carl N. Jacobs, Hardware Mutual Casualty Co., Stevens Point, financing social security benefits; C. H. Crownhart, State Medical society, Madison, health and cash disability insurance; C. C. Klocksin, Northwestern Mutual Life Insurance Co., Milwaukee, old age and survivors insurance;

K. B. Howell, Kendall Corp., Milwaukee, unemployment compensation; Frank Hughes, Mutual Benefit Life Insurance Co., Milwaukee, public pensions; and John Toohey, Gisholt Machine Co., Madison, public assistance.

Toohey and Cyril Moffit, Wisconsin Agriculturist and Farmer, Racine, are recent appointees to the committee.

Major emphasis at the committee's February 13 meeting was placed on plans for successful conclusion of the campaign against President Truman's reorganization plan which would place federal unemployment compensation and employment service activities under Labor Department control.

Howell G. Evans, Two Rivers, State Chamber president, praised the committee's vigorous leadership in opposing the reorganization plan. Mr. Silbernagel, chamber secretary, and Mr. Whittet recently appeared before House committees in Washington.

Anesthesiologists Start Series of 1-Day Courses

New Society Seeks Members

Part-time and full-time anesthetists are being urged by the Wisconsin Society of Anesthesiologists to become identified with that group and to take part in a series of courses on anesthesia starting in April.

The primary aim of the Society is education in anesthesiology. As a result, the first of a series of one-day sessions will be held in Milwaukee on Sunday, April 11. The discussion will be on "The Respiratory System in Anesthesia." The subject matter will be presented in a practical manner so as to form a concentrated, didactic course in anesthesia of particular value to the part-time doctor anesthetist.

The Society was organized in December, 1947 and received its charter in January, 1948. Its membership is open to all doctors of medicine who practice anesthesia on part or full-time basis.

Any doctor desiring to be placed upon the mailing list of the Society or desiring membership in the Society may communicate with the Secretary, Dr. William Kreul, 811 Main Street, Racine.

News of Prepayment Medical Care Plans

Early responses from member physicans and interested insurance companies evidence keen interest in the prepayment program developed by the Rhode Island Medical Society. More than 500 physicians have already agreed to participate in the Rhode Island Plan and five major insurance companies have had policies approved by the insurance committee with several others planning to submit theirs.

* * * * *

Favorable experience with temporary benefit increases for subscribers of United Medical Service, Inc., has resulted in additional benefit increases. Payment for normal obstetrical delivery was increased from $60 to $75; surgical plan subscribers now are assured of maximum payments up to $225 on physicians' fees instead of $150; and maximum hospital benefits of $200.50 for each hospital admission starting with the first day of hospitalization. The plan serves 710,000 persons in the Greater New York area.

The Connecticut Medical Society deferred for two months action on a surgical and obstetrical plan so that the plan might be studied more closely by the county societies. Meanwhile, the Wagner–Murray–Dingell bill and a 'ceiling' aid plan for hospital bills were offered as alternatives.

* * * * *

Nebraska has launched a statewide community enrollment program for Blue Cross hospital care and Blue Shield Medical Service. More than 750,000 rural families are eligible for membership under the new plan of accepting groups on a city, township or county-wide basis.

* * * * *

Michigan Medical Service is big business. Since 1940, MMS has paid $22,950,000 for services to its subscribers, $1,345,000 to veterans, making a total of $24,290,000. Michigan Hospital Service has paid $47,500,000 to hospitals. The grand total is nearly $72,000,000. Michigan Medical Service covers more than 917,000 persons.

COMMENTS FROM THE WISCONSIN PRESS

Palmyra Editor Looks at Rebate Practices

The following editorial appeared in the February 5, 1948, issue of the *Palmyra Enterprise*. It is reprinted here with permission of the editor.

"Not the Majority"

There is a censorship of certain private physicians overcharging or using unfair tactics in treating war veterans, patients not being treated in veterans' hospitals. The medical profession comes in for criticism in many places for refusing to respond to emergency calls. It is accused of tying up with drug stores, and clinical laboratories for 'kick-backs.' That there are a number of doctors receiving rebates for business steered to these houses, we don't doubt. That the field of specialists has grown so that it is difficult in cities to find a general practitioner for an emergency call, is probably true. A Palmyra man says all of this proves the point that what we need are more of the 'country doctor' type, the medico who treated all ills the best he knew how, and who took a personal interest in the patient.

Specialization in medicine is a wonderful benefit to mankind. We wouldn't be without it. As to the unethical business of fee-splitting, of chiselling, this is not confined to medicine but seems to take place in almost all professions. Our respect for the ability and ethics of men of medicine is unshaken, for this is a revered, an honored calling, and such it will remain in spite of the offenders in the field. We are grateful to the doctors of Palmyra for their humanity, their concern and their ability.

Linicome and Rasmussen Join U. W. Medical Staff

Madison.—Two appointments to the medical school staff of the University of Wisconsin were announced recently. The new members are Dr. David R. Lincicome and Dr. A. Frederick Rasmussen, Jr.

Dr. Lincicome is an authority in the field of intestinal parasites and holds the rank of assistant professor in the department of microbiology at the medical school. He received his doctorate in parasitology from Tulane in 1941.

Dr. Rasmussen joined the faculty of the medical school as associate professor of microbiology and preventive medicine.

Waupaca Paper Writes About British Medicine

The *Waupaca County Post* has been watching developments toward nationalized medicine in Great Britain. Its observations are reported in the February 26, 1948 issue of that newspaper and are reprinted here with full permission of the editor.

"Doctors Are Human, Too"

Proof is arriving from England, in the form of press releases, showing that doctors are as human as any other group of citizens. Fifty-six thousand of the British Medical Association are taking a 'strike vote' to decide whether to boycott Britain's socialized medicine scheme which the government has said will become effective next July, regardless of objections. Ironically, the leaders of the labor government call it a move to 'organize and exploit an outburst of mass hysteria among doctors.' One observed that 'we seem to have passed beyond the stage when the prime consideration is the welfare of the patient.'

There is no valid reason why doctors should not protest against a condition which they feel to be unjust and injurious to the cause of good medical care. Doctors are scientists. They spend ten or twelve years of their lives qualifying to practice in their chosen field. As far as the public welfare is concerned, the doctors have a greater awareness of their responsibilities than any other group.

The medical profession in Britain, as well as the medical profession in the United States, is opposed to the coercion and bureaucratic inefficiency of state medicine, because they believe, with good reason, that it threatens the public welfare.

It is odd indeed to witness spokesmen for labor condemning the 'strike action' of British doctors. They should be the last to cite a strike as an indication of 'mass hysteria' or prima facie evidence that the strikers no longer have the public welfare in mind.

Expert Testimony—

(Continued from page 1)

Mr. Toebaas said that he was "not condemning the entire medical profession," but recommended that the bar group study procedures of Minnesota and Massachusetts with a view to making recommendations to the legislature.

In Minnesota, the trial judge, opposing attorney or opposing physician may file a complaint with the medical testimony committee of the state medical society if he feels that the witness is intentionally not telling the truth.

Ten complaints have been received in Minnesota since 1945, Toebaas said. Four were dismissed, warnings were issued in four and two others were sent to the board of examiners for disciplinary action.

The quality of medicine which is at our beck and call cannot be valued in dollars and cents. If it could be, the price would be most reasonable.

However, when the doctor bill does arrive, it sometimes looks like the national debt to the individual who has to pay it in a lump sum.

Accident and Health, Hospital and Surgical Insurance helps soften the blow and keeps the patient on a paying basis.

It is our aim to pay all claims promptly. The attending physician can make his patient's disability insurance more efficient by the prompt dispatch of claim blanks covering the disability.

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REQUEST FEDERAL FUNDS FOR 7 NEW HOSPITALS

Seek Data on Infant and Maternal Deaths

Survey Chiefs of Staffs

Madison, Mar. 3—Chiefs of staffs of Wisconsin hospitals are being contacted by the Committee on Maternal and Child Welfare to secure more accurate information on infant and maternal mortality rates in 1947 and other pertinent data on existing hospital procedures and facilities related to the care of the newborn.

Procedures for the survey were outlined at a meeting of the committee held in Milwaukee, and questionnaries are being circulated to all hospitals of the state, according to Dr. W. C. Stewart, Kenosha, chairman.

Need More Facts

"The purpose of the survey," explained Dr. Stewart, "is to secure better and more accurate information on infant and maternal deaths than can be obtained from reports furnished to the State Board of Health. The committee is interested in learning more about stillborns than the fact that several thousand are recorded each year."

"We feel that medical facts on the fatalities can give us a better understanding of these deaths than the mere fact that they have occurred," Dr. Stewart said. "Mortality statistics on prematures and the existing facilities and practices in Wisconsin hospitals for the handling of prematures may also help us gain a better understanding of measures which can be taken to improve our experience in this field."

In launching the survey the committee is carrying out a recommendation of the House of Delegates, voted at the 1947 meeting, to contact hospitals to determine present facts concerning infant and maternal care.

Members of the committee in charge of the study are Doctors W. C. Stewart, J. W. Harris, Madison; E. C. Cary, Reedsville; R. F. Purtell, Milwaukee; L. M. Simonson, Sheboygan; and Amy Louise Hunter, director of the bureau of maternal and child welfare, state board of health.

Five General Hospitals, Mental and Chronic Ill Units to Be Constructed

Madison, Mar. 6—The state board of health has forwarded to the Surgeon General applications for federal funds for construction of seven hospitals whose aggregate costs will be more than six million dollars.

Included are general hospitals for New Richmond, Clintonville, Fort Atkinson, Viroqua, Darlington, a 240-bed medical-surgical unit for the state psychopathic hospital at Winnebago, and a 100-bed chronic disease unit for Madison General hospital.

This proposed hospital construction represents an application for $1,541,280 in federal funds, Wisconsin's first year share of the five year national plan for developing hospital facilities to the level of recognized standards.

Under the national program each federal dollar allotted must be matched by two community or state dollars of constructions costs.

Sizes of the five proposed general hospitals are as follows:

Community	Number of Beds	Total Cost
New Richmond	25	$381,500
Clintonville	50	681,450
Fort Atkinson	62	813,630
Viroqua	50	650,475
Darlington	29	351,652

Only 60% of the federal allotment is available for general hospital beds, according to Mr. Vincent F. Otis, director of the hospital survey and construction division. The remaining 40% has to be used for construction of chronic disease or mental hospitals, public health centers, and tuberculosis facilities. Money for general hospital beds is allotted by priority; funds from the 40% go to categories which the state board of health feels most urgently need the facilities.

Communities with high priorities under the program will be able to file applications for funds between now and July 1, 1948 at which time the second allocation of federal funds will be made. The project construction schedule just announced had to be made within four months of approval of the Surgeon General of the state plan last November. With the start of the second fiscal year on July 1, funds become available for the second allotment. Thus it is imperative that communities make their applications within the next three months to get in on the second allotment.

Major revision of the state plan will be made on July 1, 1949 with a view to setting up a new priority schedule. This will take into consideration hospital expansion programs with or without federal aid and give attention to local situations not considered in the original survey. Mr. Otis emphasized that the five year program will supply only one-sixth of the general hospital beds needed.

Dr. Carl N. Neupert, state health officer, pointed out that in forwarding the recent application for funds, the state board of health was executing only one of four required steps. Step One is to obtain federal assurance that the project will become a reality; Step Two is to arrange the details of financing at which time the applicant must actually have one-third of the needed cash on hand; Step Three is a site survey and soil investigation, and Step Four is to figure the exact cost after bids have been opened for the construction.

Mr. Otis reports that estimates have been difficult to make because so little construction has taken place in the hospital field in the past few years.

DOCTORS, PLEASE NOTE!

The attention of physicians is invited to the following paragraph concerning the outpatient treatment of veterans. It is found on page 2 of the "red book" revised schedule of fees of the Wisconsin Veterans Medical Service Agency.

Veterans Training under Public Law 16. Veterans receiving training under Public Law 16 (those with vocational handicaps resulting from service-connected disabilities) are entitled to out-patient treatment not only for their service-connected disabilities but also for any disability that may interfere with the pursuit of training.

National Health Assembly Called at Truman's Request

Washington, Mar. 5—Federal Security Administrator, Oscar R. Ewing, has called a National Health Assembly to be held in Washington, May 1–4. The assembly is being set up as a result of President Truman's recent message to Mr. Ewing asking him to develop feasible national health goals for the next 10 years.

Twenty-four national leaders in various fields have been invited to serve on the executive committee of the assembly. Dr. George F. Lull, secretary and general manager of the American Medical Association, is the only physician now on the committee although Mr. Ewing is said to have added the names of three others. It is estimated that 700–800 persons will attend.

An editorial in the March 6 Journal of the American Medical Association states that the Assembly "bears all the stigmas—political and propagandistic—that accompanied the National Health Assembly in 1938." That session was dominated with representatives of the Federal government promoting compulsory sickness insurance, the A. M. A. said.

Question Publicity Methods

The A.M.A. editorial stated that the present executive committee of 26 has on it 19 members who have "previously been associated with propaganda in behalf of compulsory sickness insurance." It warned that the Assembly's opening speeches—if they follow previous patterns—will be made by President Truman and Mr. Ewing endorsing nationalized medical care and will be given vast circulation by radio and press. It wonders if the same opportunity will be given those who oppose the program.

Ewing Forsees Agreement

Panel discussions on specific health problems are to be the major activity of the May sessions, Mr. Ewing said. Some of the proposed topics are "medical care, professional personnel, hospital facilities, local health units, maternal and child health, rural, dental and mental health."

Mr. Ewing stated that he considered "the request of the President one of the most important assignments ever given in peace time to a federal agency, and the projected National Health Assembly can be of tremendous value in helping the Federal Security Agency in carrying it out."

"One important thing that we hope will come out of the assembly is a clearer picture of just how much agreement there is in certain supposedly controversial health fields. I have an idea we are going to find that these areas of agreement are larger than many people think. Once we have that established, we can find out how far we can all go forward on a nationwide front. To the extent that the Assembly achieves this, it will produce a solid foundation for the ten-year program which the President has asked the Federal Security Administrator to draw up."

British Doctors Oppose Terms of Health Act; Government Will Go Ahead Despite Opposition

London, Feb. 26—A plebiscite of 56,000 members of the British Medical Association was completed recently with the result that 89.5 per cent of the British doctors disapproved of the National Health Service Act (nationalized medical plan) in its present form.

The survey also revealed that 25,340 of the doctors or 86 per cent were opposed to accepting service under the plan. The National Health Service Act, scheduled to go into operation on July 5, proposes to provide Britian's 47,000,000 people with medical and health service at government expense. Doctors would be prevented from selling their practices, the government would control where a doctor may practice, he could be dismissed from the service without court appeal, his type of practice would be restricted and the doctors would be paid a yearly basic salary of $1,200 with the remainder in the form of capitation fees of $3 a year for each person treated, mileage allowances and "extra inducements."

Make Decision in July

The recent mail vote of British medical men is only an expression of opinion concerning the terms of the Act. The doctors will actually decide to join or stay out of the plan when it goes into effect July 5.

Aneurin Bevan, minister of health, has announced that he will go ahead with the free treatment program regardless of the doctors' opposition. He has the backing of two endorsements from Parliament.

Beaumont Building May Be Open for Centennial

Prairie du Chien, Feb. 26.—The Beaumont Foundation today revealed its hopes that restoration work on the Second Fort Crawford building will be sufficiently complete to permit formal opening of the building at the Crawford County Centennial and Villa Louis program in May.

The three-room building is owned by the foundation and restoration work on the interior has been in progress for several years. The Foundation will refurnish one room while the Medical Society of Crawford County and the Daughters of the American Revolution will have charge of the other two. Each will be refurnished with articles as near like the original as possible.

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Physicians Service Pays $90,000 Benefits in First 13 Months

Madison, Mar. 1.—Nearly $90,000 has been paid out in service benefits for more than 2,000 separate medical or surgical procedures performed for subscribers to Wisconsin Physicians Service (WPS) in the thirteen months preceding January 1948, Mr. Ralph F. Weber, director, has revealed in his annual report to the directing board of WPS and the Council of the State Medical Society.

Seven-hundred and ninety-three doctors received a total of $89,561.75 for services rendered to patients covered by Wisconsin Physicians Service. The report covered the entire period since the establishment of the prepaid medical plan on December 1, 1946, but since the first months were devoted to promotional activity the figures represent coverage given after April 1, 1947 when a working agreement was reached with Blue Cross for enrolling and billing.

Figures taken from the operating statement of the annual audit show that earned income from premiums produced a total of $138,150.04 between Dec. 1, 1946 and Dec. 31, 1947. Physicians were paid a total of $89,561.75 for their services. A reserve of $20,958.28 was held for maternity benefits, unknown claims, disaster and unforseen circumstances.

A total of $27,630.01 from premium income was set aside for administrative purposes. The Council of the State Medical Society advanced $20,000 for promotional purposes during this period, making a total of $47,630.01 for administration. The accumulated administrative and promotion expense was $36,372.14 during the 13-month period leaving a reserve in the administrative account of $11,257.87.

A breakdown of the coverage, doctors actually participating and benefits is made by counties as follows:

County	Persons Covered	Doctors Paid	Benefits Paid
Adams	--	1	$ 200.00
Ashland	125	9	869.00
Barron	222	5	330.00
Bayfield	--	--	--
Brown	634	37	4,130.00
Buffalo	--	--	--
Burnett	--	--	--
Calumet	278	3	432.00
Chippewa	1,383	13	4,584.00
Clark	245	1	35.00
Columbia	418	15	2,266.00
Crawford	--	3	94.00
Dane	2,457	102	13,987.00
Dodge	1,467	20	4,725.00
Door	231	5	634.00
Douglas	1,746	17	1,123.00
Dunn	--	--	--
Eau Claire	1,817	29	3,980.00
Florence	38	--	--
Fond du Lac	470	20	2,066.00
Forest	--	--	--
Grant	26	--	--
Green	286	7	900.00
Green Lake	68	4	380.00
Iowa	--	2	42.00
Iron	80	1	30.00
Jackson	--	1	30.00
Jefferson	144	9	1,190.00
Juneau	--	1	10.00
Kenosha	203	8	735.00
Kewaunee	38	2	21.00
La Crosse	925	31	3,990.50
LaFayette	18	--	--
Langlade	26	3	95.00
Lincoln	17	3	183.00
Manitowoc	186	13	745.00
Marathon	609	25	2,486.00
Marinette	337	13	1,532.00
Marquette	--	--	--
Milwaukee	--	56	5,210.00
Monroe	281	8	906.00
Oconto	120	2	74.00
Oneida	66	3	322.00
Outagamie	954	26	2,555.00
Ozaukee	582	7	1,857.00
Pepin	--	--	--
Pierce	--	--	--
Polk	210	5	523.00
Portage	1,907	14	1,133.00
Price	--	1	42.00
Racine	839	36	2,819.00
Richland	35	4	156.00
Rock	1,152	37	3,592.50
Rusk	--	2	80.00
St. Croix	--	1	35.00
Sauk	73	12	997.00
Sawyer	--	--	--
Shawano	477	7	880.00
Sheboygan	2,570	36	4,132.00
Taylor	--	--	--
Trempealeau	47	2	170.00
Vernon	23	3	185.00
Vilas	--	--	--
Walworth	260	4	308.00
Washburn	40	1	47.00
Washington	309	5	383.00
Waukesha	1,835	21	2,393.00
Waupaca	84	8	513.00
Waushara	75	2	164.00
Winnebago	2,280	30	4,424.25
Wood	--	8	398.00
Totals	**45,378**	**793**	**$89,561.75**

VA Clarifies Procedure Used When Veteran Applies for Treatment

Milwaukee, Mar. 5—Applications by veterans for medical treatment, transmitted through physicians affiliated with the Wisconsin Veterans Medical Service agency, are accepted as informal disability claims by the Veterans Administration, according to John P. Cullen, Wisconsin regional VA manager.

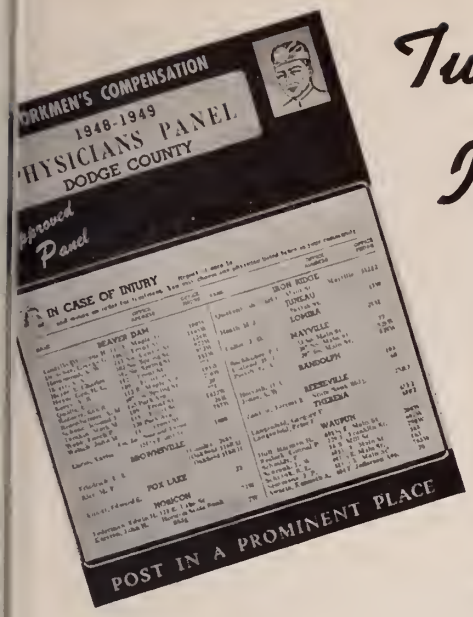
Many physicians transmitting applications for veterans have received notice that treatment could not be authorized because the veteran's disability was not service-connected, the VA manager said. In those cases, they frequently assumed the VA took no further action, he added.

Actually the VA immediately begins the steps necessary to show whether the disability requiring treatment is one incurred or aggravated in service, Cullen said. A formal claim application is mailed to the veteran and he is fully informed of the requirements in his case. His medical records are requested of the service branch to which he belonged.

Under former regulations treatment could be authorized immediately, if the veteran could offer reasonable proof that the disability was incurred or aggravated in service, Cullen pointed out. Since January 1, 1948, however, a definite determination of service-connection has become a pre-requisite, he explained.

Only veterans attending school or training on the job under Public Law 16 are exempt from the latter requirement, it was emphasized. Those cases may receive any medical and dental treatment necessary to prevent interruption of training, regardless of whether the condition is service-connected, Cullen concluded.

Recognition of applications sent through physicians as informal claims is important to both the physician and the veteran because medical treatment following the date of claim will be paid for by the VA in many instances if the disability is later adjudged service-connected, Cullen said. In a large percentage of cases, the date of claim is considered to be the official beginning of the veteran's period of eligibility and neither the physician nor the veteran can be reimbursed for treatment rendered before that date.



Two Important Publications for benefit of

SMS MEMBERS

COMPENSATION PANELS

All employers covered by Workmen's Compensation insurance have been supplied with panels carrying the names of SMS members who have indicated a desire to participate in the program. These panels will be in force during 1948–49.

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INDUSTRIAL GUIDE

Here is a new publication by the Committee on Industrial Health of the State Medical Society of Wisconsin and the Industrial Hygiene Unit of the State Board of Health which is *free to all members of the State Medical Society, industrial nurses, and top management.* Just send the coupon at the bottom of this page, either pasted on a penny postal card or enclosed in an envelope addressed to the State Medical Society of Wisconsin, 917 Tenney Building, Madison 3, Wisconsin.

Contents

- Relationships of MDs to an Industrial Health Program
- Relationships of Industrial Nurses to MDs and Employers
- Medical Ethics in Industrial Health
- Standing Orders for Nurses in Industry (specific orders for 46 industrial injuries)
- Nursing Care of Eyes in Industry
- Standards for the Pregnant Worker
- Antidotes — Respiration — Pressure Points — Bandaging — Toxic Agents

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Gentlemen:

Send me a copy of your new publication "Industrial Health, A Guide for Medical and Nursing Personnel", which will be furnished me without cost.

Signed _____

Street _____

City _____

The Veterans' Administration has put the clamps on the GI student subsistence law recently passed by Congress to be effective April 1. The VA says it will not pay the increased benefits to those attending part-time classes at schools, colleges or universities; those in farm training even if part of it is in college; apprentices or on-the-job trainees; those who split training between on-the-job and classroom; interns or residents in training in hospitals; and those taking graduate training in colleges, requiring a reduced schedule of classes.

* * *

British Cooperatives have acquiesced to national ownership of public services and resources, but feel differently about consumer goods and services. They said: "The cooperative movement is ready to collaborate with the Labor Government . . . But, let us make it clear once and for all that the cooperative movement has no intention of merging the economic organization it has created, or the principles and traditions which it upholds, with State or municipality —or regarding State or municipal activity, in the sphere in which it has concerned itself, as any substitute for cooperative action."

* * *

A rural survey made by the Conference Committee on Health Insurance of 10 national insurance associations showed that 7,120,378 people in rural areas were covered by some form of accident and health or hospitalization insurance in 1947. This is 18% increase over 1946. "Rural areas" were those of 2,500 population or less.

* * *

The Armed Services committee has been asked to investigate why the taxpayers should pay $100 a minute to Fred Waring's orchestra for two half-hour weekly programs to help army recruitment. The program is on the air in Wisconsin at 9 a.m. when young men who might enlist are either at work or in school and so can't hear it. The program is said to be aimed at changing mothers' attitudes toward army service.

* * *

Representative Frank B. Keefe of the 6th Wisconsin District introduced a bill in the House on January 21 to provide for research and control relating to diseases of the heart and circulation. The measure would among other things set up a National Heart Institute patterned after the National Cancer Institute.

Veterans Agency Advises on Treatment of Veterans

Madison, Mar. 8.—At a recent meeting of the Operating Committee of the Wisconsin Veterans Medical Service agency and the Veterans Administration, Dr. J. S. Supernaw, chairman, and Mr. T. J. Doran, director, discussed the following points which will be of information to physicians treating veterans:

1. Even if a veteran has a service-connected disability the government will not pay for the medical care of the disability until *after* the veteran has filed a claim for that disability. Many veterans have been paying their own medical bills and have resisted making out any claims. When Form 100 is presented to the VA requesting authority to treat the veteran, the request is denied because service-connection has not been established. Doctors may wish to pass this information on to their veteran patients.

2. When a physician has authority to treat a veteran and penicillin is used in the treatment of the service connected disability, the V.A. will pay the physician $2.50 for 300,000 units of penicillin plus the cost of an office call.

3. Many physicians are requesting Code No. 0012 in the WVMSA "red book." This procedure is to be used only for pension examinations. It is a complete physical examination including urinalysis. It is recommended that an office call plus the necessary laboratory work be requested instead of Code No. 0012.

4. The VA informed the agency of a new regulation which calls for cancellation of all authorities for treatment not presented within 45 days after their expiration date.

Dr. Clark Exposes Dangers of Compulsory Medicine to Oshkosh Candlelight Group

Oshkosh—Sound opposition to compulsory plans for medical care was registered by Dr. William E. Clark, Oshkosh, in an address before the Candlelight Club on January 20. Disputing a round figure of 5,000,000 men which President Truman has said were rejected for military service because they were unfit, Dr. Clark said the United States is a healthier place than at first seemed.

"It is doubtful if more than 10 to 15 per cent of the total number of men rejected could have been made available (through medical care) for military service."

Dr. Clark declared that actually 4,217,00 men or 783,000 less than President Truman's figures were rejected in the recent war. In a breakdown of why they were rejected, he said that 701,700 were rejected for mental diseases; 582,-100 for mental deficiencies, including 250,000 illiterates, and large numbers of others for reasons which doctors could not control.

Praises Voluntary Insurance

Dr. Clark contended that "compulsory medical insurance with all of its threats of socialization not only of the medical profession, but also of the entire country, is being relentlessly forced on citizens of the United States and one of the counter measures being offered by free enterprise is a plan of voluntary prepayment health insurance which may or may not be effective in stemming the tide, but which no matter what the outcome, still offers at present a fair and equitable method for the public to budget its sickness costs."

He pointed out that other countries with compulsory medicine have fewer physicians per thousand population, costs have pyramided so that the government is required to have one employee for every 50 individuals covered, and the standards of medical care have deteriorated.

Declaring that a great many medical men have had their heads buried, like the ostrich, "in the hope that the ever growing paternalism of our Government would pass us by" he said there "is no question that compulsory sickness insurance is one of the first steps toward complete socialism."

(Continued from page 314)

"The Indications for Surgical Procedures in Cancer of the Rectum Based on Pathological Considerations"

Vernon C. David, M. D., professor of surgery, University of Illinois College of Medicine

8:15 p. m.

The Medical Society of Milwaukee County, monthly meeting, Milwaukee Athletic Club, Elizabethan Room

Moderator: **Joseph C. Griffith, M. D.,** president of the Medical Society of Milwaukee County

"Cancer of the Breast"

Frank Adair, M. D., associate professor of surgery, Cornell University Medical College, New York

Saturday, April 10

2:00 p. m.

Marquette University School of Medicine Auditorium

"Slide Seminar on Dermatological Lesions"

Conducted by **Arthur C. Allen, M. D.** for the Wisconsin Society of Pathologists. All interested physicians are invited to attend.

RECENT WISCONSIN LICENTIATES

At a meeting held in Madison on January 13, 14, and 15, the Wisconsin State Board of Medical Examiners licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Balliet, Charles M.	Marquette	1946	Deaconess Hospital, Milwaukee
Benkendorf, Charles	Marquette	1946	1718 South Twenty-Fourth Street, Milwaukee
Bowden, Robert Horton	Marquette	1946	722 North Thirteenth Street, Milwaukee 3
Brandt, Eugene F.	Marquette	1946	3412 North Forty-Sixth Street, Milwaukee
Brechtl, Harvey James	Marquette	1946	1521 South Seventy-Sixth Street, West Allis
Brown, Ward Everett	Marquette	1946	527 Grove Street, Waukesha
Buessler, John Aure	Wisconsin	1944	651 University Avenue, Madison 5
Buhl, Thomas Lorenz	Marquette	1946	909 Fourth Street South, St. James, Minnesota
Chambers, Richard Kelly	Marquette	1946	3248A North Twelfth Street, Milwaukee
Chapman, Jeane Louise	Wisconsin	1946	State of Wisconsin General Hospital, Madison
Darrow, Clarence A.	Iowa	1934	1250 South Grandview Avenue, Dubuque, Iowa
Engels, Donald Henry	Marquette	1946	342 Main Street, Darlington
Fenzl, Robert C.	Marquette	1946	147 Juniper Street, Lockport, New York
Foley, Thomas Jennings	Marquette	1946	6713 West Wisconsin Avenue, Wauwatosa
Frisch, John George	Marquette	1946	4830 North Berkeley Street, Milwaukee
Heinz, Harold N.	Marquette	1946	1115 East Lyon Street, Milwaukee 2
Higley, Richard Alan	Marquette	1945	2907 Parkridge, Marinette
Hobbins, William Bell	Northwestern	1947	2415 Norwood Place, Madison
Hohler, Eugene Joseph	Marquette	1946	1957 South Eighty-Ninth Street, West Allis
Hotter, John Thomas	Marquette	1946	1563 South Seventy-Second Street, West Allis
Leslie, Charles L.	Marquette	1946	320 Eighth Street, Waverly, Iowa
Le Tellier, Mason S.	Marquette	1946	2540 North Forty-Fifth Street, Milwaukee
Lorenz, Albert Arthur	Northwestern	1944	509 North Lake Street, Madison
Lukes, William Creighton	Marquette	1945	Veterans Administration Hospital, Fort Benjamin Harrison, Indiana
Lynch, John Mark	Michigan	1946	1916 Eleventh Street, Monroe
McGuire, George Edward	Marquette	1946	4062 North Sixteenth Street, Milwaukee
Majewski, Joseph T.	Marquette	1945	3117 North Dousman Street, Milwaukee
Mokris, George	Marquette	1946	1820 Forestdale, Cleveland, Ohio
Nagan, Robert F.	Marquette	1946	611 Quinney Avenue, Kaukauna
Oppert, Harold E.	Wisconsin	1946	5115 Byers Avenue, Fort Worth, Texas
Panagis, Constantine	Marquette	1946	13730 West Capitol Drive, Milwaukee
Pember, John Frank	Northwestern	1946	703 Court Street, Janesville
Puchner, Thomas C.	Marquette	1946	9719 Harding, Wauwatosa
Rahn, Bruno F.	Marquette	1945	7015 West Wells Street, Wauwatosa
Redlin, Russell Robert	Marquette	1946	3270 South Forty-Fifth Street, Milwaukee
Saichek, Herbert B.	Marquette	1943	2803 North Fifty-Second Street, Milwaukee
Sattler, Marvin Edward	Marquette	1946	2803 North Forty-Eighth Street, Milwaukee
Schaefer, Harry E.	Marquette	1946	1015A Washington, Manitowoc
Schaefer, Margaret Ann	Wisconsin	1946	Gundersen Clinic, La Crosse
Scheller, Robert F.	Marquette	1946	1915 East Newberry Street, Milwaukee
Schmidt, Lou Robert	Marquette	1946	1233 Ferry Street, La Crosse
Schmidt, Robert Eugene	Marquette	1946	2344 North Forty-First Street, Milwaukee
Schmitt, George Donald	Marquette	1946	826 North Cass Street, Milwaukee
Schroeder, Robert Walter	Marquette	1946	282 Cottage Avenue, Fond du Lac
Settlage, Calvin F.	Wisconsin	1945	Veterans Administration Hospital, Marion, Indiana
Smith, Nathan James	Wisconsin	1945	530 Dewey Street, Wisconsin Rapids

Name	School of Graduation	Year	Address
Soffer, Alfred	Wisconsin	1945	Veterans Administration Hospital, Northampton, Massachusetts
Soltero, Donald E.	Marquette	1944	1919 Martha Washington Drive, Wauwatosa
Sroka, William Charles	Marquette	1946	4204 North Twenty-Second Street, Milwaukee
Taniguchi, Tokuso	Tulane	1946	St. Joseph's Hospital, Milwaukee
Terveer, John B.	Marquette	1946	604 Madison, Decatur, Indiana
Thompson, Loren L.	Marquette	1946	2403 West Greenfield, Milwaukee
Tratar, Anton Andrew	Marquette	1946	1947A North Twenty-Sixth Street, Milwaukee
Tuchscherer, Mabel Evelyn	Marquette	1946	617 Locust Street, Anaconda, Montana
Van Liere, John Donald	Marquette	1946	Salem
Wurtz, Keith George	Northwestern	1947	Elmwood
Zimmer, James Francis	Marquette	1946	Colgate

At a meeting held in Madison on January 13–15, the Wisconsin State Board of Medical Examiners granted licenses through reciprocity to the following physicians.

Name	School of Graduation	Year	Address
Anderson, Alton D.	Wisconsin	1943	317 West Mifflin St., Madison
Anderson, Ralph T.	Temple	1940	16 St. Albans Road, Superior
Davis, Adrian W.	Illinois	1943	3118 Center Ave., Madison
Gardner, Weston D.	Pittsburgh	1942	Marquette Univ. School of Med., Milw.
Graiewski, Stanley J.	Minnesota	1945	200 East Ridge St., Ironwood, Mich.
Hall, Robert Wade	Nebraska	1943	Milwaukee County Hospital, Milwaukee
Harris, Henry W.	North Carolina	1943	Gundersen Clinic, La Crosse
Johnson, Frank K.	Illinois	1942	507 Orchard Lane, Winnetka, Ill.
Kaemerle, Harold K.	Illinois	1944	5116 North Mango St., Chicago
Kagen, Marvin S.	Illinois	1941	180 North Michigan Ave., Chicago
Koop, Chester S.	Long Island College of Medicine	1942	Rocky Knoll Sanitarium, Plymouth
Leahy, James J.	Northwestern	1945	477 First Ave., North, Park Falls
McAtee, John D.	Rush	1937	630 Scott St., Covington, Ky.
McCormack, Robert M.	Chicago	1943	Strong Memorial Hosp., Rochester, N. Y.
Marck, Abraham	New York	1939	425 East Wisconsin Ave., Milwaukee
Mulvaney, John J.	Loyola	1944	Winnebago State Hospital, Winnebago
Norum, Henry Alvin	Minnesota	1944	Linden Home Farms, Nashotah
Ponath, Raymond E.	Wisconsin	1945	1834 West Vliet St., Milwaukee
Seifert, William F.	Illinois	1936	303 North Main St., Rockford, Ill.
Simon, George M.	Wisconsin	1944	833 South Eighth St., Manitowoc
Steffen, Elizabeth A.	McGill (Canada)	1945	503 Fifth Ave., Antigo
Stelter, John H., Jr.	New York	1939	8928 Ninety-Seventh St., Woodhaven, N.Y.
Straughn, Robert A.	Temple	1940	Jackson Clinic, Madison
Tanner, William A.	Kansas	1944	4603 Melvin St., Kansas City, Kan.
Tomlin, Clyde E.	Oklahoma	1945	State Sanatorium, Statesan
Whiting, Adolph M.	Minnesota	1945	2400 Vincent Ave., N., Minneapolis, Minn.

COMMENTS ON TREATMENT

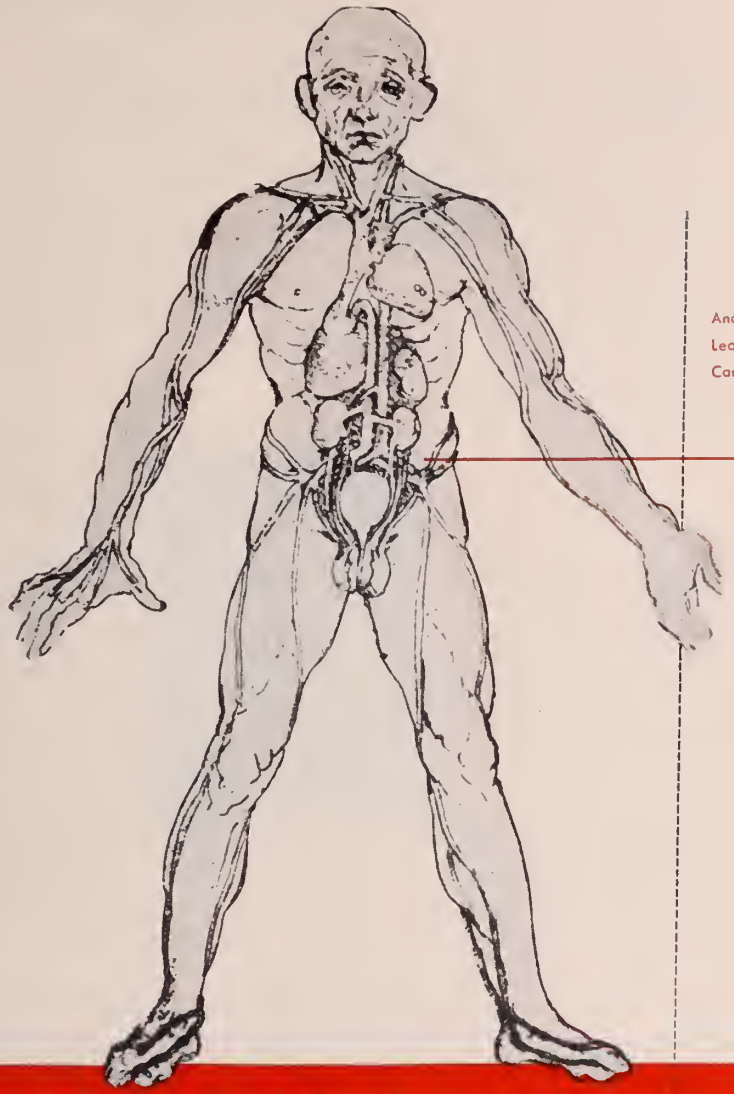
(Continued from page 306)

seeming to have a very low resistance to such infections. Capps and Barker found alcohol frequently producing severe exacerbations and felt it to be absolutely contraindicated in all stages of the disease. Cathartics of all sorts appeared to be harmful also, probably because of the associated diarrhea; constipation should be combatted by enemas. Opiates and the short-acting barbiturates that are probably detoxified by the liver have a prolonged and exaggerated effect in the presence of liver disease. Capps and Barker said that they had seen fatal morphinism after ½ grain (30 mg.) and that they had known patients to sleep for thirty-six hours after 3 grains (0.2 gm.) of amytal.—HARRY BECKMAN, M. D.

AS IT LOOKS TO YOUR STATE BOARD OF HEALTH

(Continued from page 312)

local groups, the application of mental hygiene principles to everyday life is brought home to people in all areas. Lectures, study courses and professional in-service training programs are promoted. Medical societies are assisted in bringing to their meetings speakers to discuss psychiatry as applied to general practice and to promote the physicians' work with beginning emotional difficulties. Patients come to their own physicians with personal problems or symptoms revealing they have conflicts. They need direct help or referral for such help. It is for that reason that the State Department of Health is promoting educational and clinical programs in preventive psychiatry.—EUGENIA S. CAMERON, M. D.



Anatomic drawing by
Leonarda da Vinci—
Courtesy, The Bettmann Archive.

Leonardo da Vinci (1452-1519)

was well ahead of his time, for physicians of his day knew little of the function of the heart or the treatment of its diseases, although da Vinci's knowledge of such anatomy was extensive.

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—a modern treatment for congestive heart failure, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration.

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SOCIETY PROCEEDINGS

Brown—Kewaunee—Door

Meeting at the Hotel Northland in Green Bay on February 12, members of the Brown–Kewaunee–Door County Medical Society heard a panel discussion by staff members of the State Medical Society. Participating in the panel were Mr. C. H. Crownhart, secretary of the State Medical Society; Mr. Thomas J. Doran, director of Wisconsin Veterans Medical Service Agency; Mr. Ralph Weber, director of Wisconsin Physicians Service; and Mr. L. R. Wheeler, executive secretary of Associated Hospital Service, Inc.

Douglas

Dr. Margaret Hatfield, health officer of District 9, spoke at a meeting of the Douglas County Medical Society on February 4 at Hotel Superior in Superior. She discussed the establishment of child guidance centers, postgraduate pediatrics, and obstetric clinics. At the business session, the new VA fee schedule, establishment of a cancer clinic, and the spring district conference were topics for discussion.

Eau Claire—Dunn—Pepin

When the Eau Claire–Dunn–Pepin County Medical Society met at the Elks Club in Eau Claire on February 23, members heard a talk by Dr. Mancel T. Mitchell of Minneapolis. Doctor Mitchell spoke on "Obstetric Hemorrhage."

Jefferson

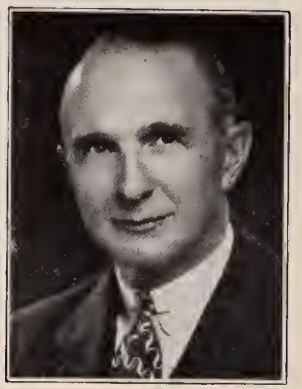
M. J. THORNTON

Dr. Madeline J. Thornton addressed the Jefferson County Medical Society at its meeting at the Blackhawk Hotel in Fort Atkinson on February 19. Doctor Thornton, who is associate professor of obstetrics and gynecology at the University of Wisconsin Medical School, spoke on "Cesarean Sections," with special reference to indications for the same. *Dr. Llewellyn R. Cole*, coordinator of graduate medical education at the University of Wisconsin, reviewed the courses available at the medical school.

Marathon

A meeting of the Marathon County Medical Society was held on January 27, following a 6:30 dinner at Hotel Wausau. The evening was devoted to a discussion of the Blue Cross and Wisconsin Physicians Service. Conducting the discussion were Mr. L. R. Wheeler, executive secertary of Associated Hospital Service Inc.; Mr. George Nauert, assistant executive secretary of Associated Hospital Service, Inc.; and Mr. Ralph Weber, director of Wisconsin Physicians Service.

Marinette



R. S. CRON

A round-table discussion followed the presentation of a paper by *Dr. Roland S. Cron*, Milwaukee, at a meeting of the Marinette County Medical Society on January 21 at the Marinette Hotel in Marinette. The subject for discussion was carcinoma of the cervix. Dr. Schellum of Battle Creek, Michigan, was present to outline plans for organization of a tumor clinic.

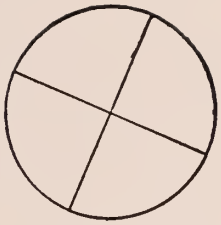
Racine

Two Milwaukee physicians were guest speakers at a meeting of the Racine County Medical Society held at the Racine Country Club on February 19. *Dr. M. C. F. Lindert* spoke on the "Differential Diagnosis in Jaundice," illustrating his talk with lantern slides. He emphasized the necessity for and means of identifying intrahepatic and extrahepatic jaundice. *Dr. James Topp* presented a paper on "Technique and Use of Needle Liver Biopsy." At the business meeting a preliminary report was made by the Industrial Health Committee on the forthcoming industrial clinic being sponsored by the Society on April 21. A committe was appointed to study the problem of immunization locally and to present a report and recommendation, and the Committee on Medical Economics was requested to make an up-to-date survery of the problem of prepayment medical service plans sponsored by the State Medical Society.

Richland

"Diagnosis and Treatment of Chest Diseases" was discussed by *Dr. James Wilkie* of Madison at the February meeting of the Richland County Medical Society. The meeting was held at Richland Hospital on February 3.

For medically sound reduction of overweight...



Benzedrine Sulfate—rational and accepted

Benzedrine Sulfate, by safely depressing the overweight patient's appetite, ordinarily curbs excessive eating. Lowered caloric intake and loss of weight naturally follow. Hence, Benzedrine Sulfate therapy is medically sound and highly effective.

Thyroid—irrational, potentially dangerous and widely condemned

In overweight, most authorities strongly condemn thyroid therapy as irrational and potentially dangerous, except in those rare instances when an accompanying hypothyroidism has been definitely demonstrated.

Benzedrine Sulfate—unlike thyroid—ordinarily, in the proper dosage, has no significant effect on the basal metabolic rate, blood pressure, or heart rate. Harris, Ivy and Searle,[1] after a comprehensive series of functional tests, conclude: "No evidence of deleterious effects of the drug (amphetamine sulfate) was observed."

[1]Harris, S. C.; Ivy, A. C., and Searle, L. M.: THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT: A Consideration of the Theory of Hunger and Appetite, J.A.M.A. 134:1468 (Aug. 23) 1947.

Benzedrine* Sulfate

Tablets Capsules Elixir **One of the fundamental drugs in medicine**

Accepted by the Council on Pharmacy and Chemistry of the AMA for use in treatment of overweight.

Smith, Kline & French Laboratories, Philadelphia

*T.M. REG. U.S. PAT. OFF. FOR RACEMIC AMPHETAMINE SULFATE, S.K.F.

Walworth

Entertaining the Auxiliary at a dinner on February 12, members of the Walworth County Medical Society gathered at the Colonial Hotel in Delavan for their meeting. *Dr. Howard Correll* of Milwaukee was the guest speaker, talking on the "Recognition and Treatment of Heart Disease."

Waukesha

The Waukesha County Medical Society met at the Avalon Hotel in Waukesha on February 4. "Diagnosis and Treatment of Back Injuries" was discussed by *Dr. Joseph Stone* of Milwaukee.

Wisconsin Surgical Society

At the semiannual meeting of the Wisconsin Surgical Society, held in Milwaukee on February 14, Dr. Nathan A. Womack, associate professor of surgery at Washington University School of Medicine, St. Louis, was the guest speaker.

Operative clinics conducted at Veterans' Hospital, Wood, and the Milwaukee County Hospital and a dry clinic conducted at the Milwaukee Children's Hospital constituted the morning session. The subjects presented at the morning dry clinic were as follows:

Congenital Hypertrophic Pyloric Stenosis—*John Erbes*, Milwaukee.
Rh–Hr Sensitization and Hemolytic Diseases of Newborn—*Dann B. Claudon*, Milwaukee.
Intestinal Obstruction in Children—*Donald S. Thatcher*, Milwaukee.
Hip Lesions in Children—*D. W. McCormick*, Milwaukee.
Complications of Meckel's Diverticulum—*Hilbert N. Dricken*, Milwaukee.
Surgical Correction of "Funnel Chest"—*Paul F. Hausmann*, Milwaukee.
Melanoma of the Foot, *Joseph J. Gramling, Jr.*, Milwaukee.

In the afternoon the scientific program was conducted at the Milwaukee Children's Hospital, at which the following papers were presented by members of the Society and discussed by the Society members:

Carcinoma of the Gallbladder—*Lawrence D. Quigley*, Green Bay.
Duodenal Diverticulum—*J. W. McRoberts*, Sheboygan.
Gastric Resection and Vagotomy—*W. B. Gnagi, Jr.*, Monroe.
The Clinical Application of Etamon (Tetraethyl-Ammonium Chloride)—*T. J. Snodgrass*, Janesville.
Fascia Lata in the Treatment of Inguinal Hernia—*Leslie Tasche*, Sheboygan.
Regional Enteritis—*Marvin Henry Steen*, Oshkosh.

At the dinner meeting in the evening, held at the University Club, a short business session was held, and following this a memoriam was given to *Dr. Curtis A. Evans*, presented by *Dr. Charles S. Rife* of Milwaukee. Dr. Nathan A. Womack then addressed the Society on "Biopsy of the Liver."

News Items and Personals

Robin Smith Enters Practice With Father

Dr. Robin Smith, recently released from the Navy, has entered practice with his father, *Dr. T. D. Smith*, at Neenah. During his naval duty, he was located at the Argentia Naval Base in Newfoundland following a year's internship at St. Alban's Naval Hospital.

Scouts Erect Memorial to Two Physician Leaders

Honoring *Drs. C. S. Phalen* of Sparta and *W. E. Bannen* of La Crosse, both of whom died in 1947, the Boy Scouts of the Gateway area will dedicate the proposed health lodge at their camp near Galesville to their memory. The structure, to be named the Bannen–Phalen Memorial, will commemorate two physicians who were active leaders in scouting, members of the executive board of the council, and recipients of the Silver Beaver, highest award given in scouting.

The health lodge will be used for physical checkups of the scouts and for first aid treatment. Many contributions have already been received for the project.

Muscoda Physician Opens New Clinic

Dr. E. T. Ackerman, Muscoda, opened his new office and clinic building in that community on February 23. The six room structure includes a waiting room with modern equipment, two examining rooms, a laboratory and supply room, and a dark room.

Academy of Practitioners of Southern Wisconsin

Members of the Academy of Practitioners of Southern Wisconsin gathered at Burlington on February 5 to elect officers for 1948. Those named to official positions were *Drs. Leonard Rauen*, Kenosha, president; *J. C. Cook*, Racine, vice-president and *Louis T. Baehr*, Janesville, secretary-treasurer.

Helen Crawford Davis to Head Radiology Department at Wausau Hospital

Dr. Helen Crawford Davis was recently appointed head of the department of radiology at Wausau Memorial Hospital. Her appointment is part of the reorganization and expansion program in the x-ray department of that hospital. Doctor Davis, who was

INSEPARABLY RELATED

"Now that we know the chemical nature of most of these compounds [internal secretions], and have learned much about their physiological activities, endocrinology has become an exact science, or branch of science, *inseparably related* to physiology, pharmacology and biochemistry."

Cameron, A. T.: Recent Advances in Endocrinology, ed. 5, Philadelphia, The Blakiston Company, 1945, p. 1.

The ever-widening scope of hormone therapy is the outcome of decades of progress in laboratory research, clinical investigation and pharmaceutical manufacture.

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world's largest manufacturer of sex hormones has pioneered in noteworthy developments in this field.

Further advances in endocrine treatment foreshadowed by current scientific activity are inseparably related to the continuing initiation of effective, well-tolerated therapeutic agents.

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formerly director of the x-ray department of the Indianapolis City Hospital, Indianapolis, has spent the past three and one-half years as head of the radiology department of St. Mary's Hospital, Wausau.

Superior Doctor Completes Sixty-Seven Years of Practice; Can You Beat It?

Dr. William E. Ground of Superior, who has practiced medicine for sixty-seven years, believes that no other physician in the country can claim a longer period of unbroken service. If there is one, the State Medical Society of Wisconsin would like to know about him.

The doctor located in Superior in 1891, after several years of practice in Ohio and New York and a period of postgraduate study in England. He served as health commissioner of Superior and in 1895 was named surgeon for the Mesabi division of the Great Northern Railroad. At present he is completing a book relating his experiences from the time he entered practice in Linton, Indiana, at the age of 20.

Medical Center Opened at Markesan

Recently opened at Markesan was the new medical center, built to handle cases of minor surgery, tests, and emergency cases. The building has been under construction since June 1947. Physicians on the staff are *Drs. Dowe P. Cupery* and *Russell S. Pelton.*

Medical Clinic to Be Established at Waupun

Drs. Raymond and *Leonard Schrank,* physicians at Waupun, have purchased a residence in that city for use as a medical clinic. When remodeling is finished, there will be facilities for complete diagnostic treatment.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—Editor's Note

SOCIETY PROCEEDINGS

Dane

Meeting at the Madison Club on February 10, members of the Dane County Medical Society heard a talk by Dr. Wallace Herrell of Mayo Clinic. His subject was "Present Trends in Antibiotic Therapy." *Dr. John Brown,* Madison, presented the discussion.

THIRD DISTRICT NEWS

R. H. Barter Accepts Post in Washington, D. C.

Dr. Robert H. Barter, senior resident in obstetrics and gynecology at the State of Wisconsin General Hospital, has accepted the position as chief medical officer in obstetrics and gynecology at the Gallinger Public Hospital in Washington, D. C. Doctor Barter graduated from the University of Wisconsin Medical School in 1940 and served in the Army Medical Corps following internship.

Bardeen Memorial Lecture Delivered by Chicago Professor

Dr. George W. Bartelmez, professor of anatomy at the University of Chicago, The School of Medicine, delivered the Dr. Charles R. Bardeen Memorial Lecture in the auditorium of the Service Memorial Institutes on February 17. This annual lectureship is sponsored by Phi Chi Medical Fraternity at the University.

Doctor Bardeen was the first dean of the University of Wisconsin Medical School, serving in that capacity from 1907 until his death in 1935. In addition, he was professor of anatomy in the medical school during that period.

N. A. Frankenstein Named Airline Pilot Examiner

The appointment of *Dr. N. A. Frankenstein,* Madison, as medical examiner for commercial pilots has been extended to include airline pilots, according to a recent announcement by the Civil Aeronautics Administration. Doctor Frankenstein is a flying enthusiast and pilot and is active in the aviation field.

Beloit Hospital Staff Selects New Officers

Dr. R. S. Vivian was named president of the staff of Beloit Hospital early in February when members of the group held their annual meeting. He succeeds *Dr. H. W. Kishpaugh* to the position. *Dr. C. M. Carney* was elected vice-president and *Dr. D. M. Clark,* secretary. *Drs. Kishpaugh, R. H. Gunderson,* and *George H. Peterson* were named members of the executive committee.

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A fifty bed hospital and sanitarium. Separate buildings for neurotic and psychotic cases.

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THIRD DISTRICT PHARMACISTS

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102 King Street, Phone: Badger 278
MADISON 3, WIS.
Mail Service Daily on Prescriptions and Stock Orders

Biologicals—Chemicals—Drugs
FIRST CENTRAL DISPENSARY
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RELIABLE PRESCRIPTION SERVICE

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Prescription Druggist
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Ampoules, Biologicals, Chemicals, Bacteriological Stains, Trusses, Camp Surgical Supports, "Leeches"
THE PRESCRIPTION PHARMACY
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Prescription Service at
RENNEBOHM
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★ ROCK COUNTY ★

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Dependable Prescription Service
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Beloit, Wisconsin

Drs. M. K. Green and August Sauthoff Retire from State Hospital Staff

M. K. GREEN

AUGUST SAUTHOFF

Health and welfare officials recently paid tribute to Drs. M. K. Green and August Sauthoff as they retired from their positions at Mendota State Hospital after a combined total of eighty-seven years of state service. Doctor Green was on the staff for forty-seven years, for twenty-four years as superintendent. Doctor Sauthoff served forty years, the last twenty-three as assistant superintendent.

Both men are considered top men in the psychiatric field in Wisconsin, and their continued and efficient service was responsible for the raising of mental care standards at Mendota and other hospitals around the state. Their work is all the more significant in view of the shortage of personnel and facilities that have long hampered proper development of such institutions.

One of their most important contributions to the state has been the outstanding cooperation they gave to medical students who received psychiatric training at Mendota. Both are noted for the invaluable personal consideration given to patient and family alike.

Doctor Green came to Mendota in 1901 as assistant physician. For three years he was chief of staff of the Wisconsin Psychiatric Institute then housed at Mendota, and since 1924 he has been superintendent of the hospital.

Doctor Sauthoff began his work at Mendota in 1906, and except for periods of research abroad, he has been in continuous service at the hospital. He is widely known for his work in the preventive field of mental diseases, particularly through outpatient clinics.

C. A. Baumann Honored by Great Britain

Dr. C. A. Baumann, professor of biochemistry at the University of Wisconsin and cancer research expert, last month was awarded the Most Excellent Order of the British Empire for his wartime work. Lord Inverchapel, the British ambassador, announced the awards, which were presented Doctor Baumann and three other Midwest scientists.

Doctor Baumann, a member of the University staff since 1929, during the war was a member of ALSO, a high-secret intelligence mission operating in the European theater.

H. M. Guilford Retires from State Board of Health

H. M. GUILFORD

An epidemiologist by profession, an ornithologist by avocation, and for many years director of the communicable disease division of the State Board of Health by virtue of his outstanding ability, is the record of Dr. Harry M. Guilford, who has been with the State Board of Health since 1921.

Doctor Guilford retired officially from state service on January 31. He was a graduate of the University of Minnesota Medical School in 1898. Although a native of Wisconsin, Doctor Guilford did not return to join the State Board of Health as epidemiologist until twenty-three years after his graduation.

In addition to his great contribution to the state in that capacity, he served until recent years as head of the communicable disease division. His long years of faithful service played an important part in making Wisconsin one of the healthiest states in the nation.

SOCIETY PROCEEDINGS

Milwaukee

Hypoglycemia was discussed by Dr. J. W. Conn of the University of Michigan Medical School at a meeting of the Medical Society of Milwaukee County at the Athletic Club on February 13. Dr. Ronald R. Greene, Chicago, talked on the treatment of diseases of women in the doctor's office.

Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine heard a talk by Dr. Jerome W. Conn, Ann Arbor, Michigan, at a meeting on February 17 at the University Club. Doctor Conn, associate professor of internal medicine at the University of Michigan Medical School, spoke on "Hypoglycemia."

Milwaukee Neuro-Psychiatric Society

Meeting at the University Club on February 18, members of the Milwaukee Neuro-Psychiatric Soci-

Pioneer's

KNOW-HOW

Included on the list of quality products which doctors recommend is Page Special Evaporated Milk — a product of one of the oldest names in the canned milk industry. To Charles A. Page (U. S. Consul at Zurich, Switzerland) goes credit for organizing the original canned milk plant, 1865, in Switzerland.

From the heritage of family know-how, comes *Page Special* Evaporated Milk, fortified with the twin vitamins A and D — an addition to vitamin D fortification, which Page also helped pioneer. The twin life-protecting vitamins are extracted from the natural source, fish liver oil. They are biologically assayed which gives Page Special an unvarying vitamin A and D potency.

Page products have become established by meeting exacting tests of the pioneer's school of hard knocks. It is no wonder that doctors, through their own experience, have found Page to be a dependable, superior quality product.

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ety heard a talk by Dr. Ladislas J. Meduna of Chicago. Doctor Meduna discussed "Carbon Dioxide Inhalation Treatment of the Psychoneuroses."

Milwaukee Oto-Ophthalmic Society

Member of the Milwaukee Oto-Ophthalmic Society were guests of the eye, ear, nose, and throat staff of Mount Sinai Hospital at a dinner meeting on February 24.

Milwaukee Metropolitan Section of American College of Chest Physicians

The Milwaukee Metropolitan Section of American College of Chest Physicians met January 30 at the Medford Hotel. Dr. Emil Rothstein, Wood, presented a paper on "Basal Tuberculosis," which was followed by a round-table discussion.

TWELFTH DISTRICT NEWS

Radiologists Confer in Milwaukee

More than two hundred midwestern physicians specializing in the use of x-ray and radium in diagnosis and treatment of diseases met at the Hotel Schroeder on February 6 and 7. The conference was under the auspices of the Milwaukee Roentgen Ray Society.

Guest speaker at the dinner on Friday was Dr. Robert R. Newell, professor of radiology at Stanford University School of Medicine, who has been associated with the atomic energy program. He spoke on the doctor's duty and responsibility in the atomic age. Other prominent lecturers on the program were Drs. Edwin C. Ernst, St. Louis, president of the American College of Radiology; Warren Furey, Chicago, president of the Cook County (Illinois) Medical Society; and R. C. Beeler, Indianapolis, past-president of the American Roentgen Ray Society.

SOCIETY RECORDS

New Members

Gordon S. Riegel, St. Croix Falls.

Harvey L. Burdick, Milton.

Earl J. Netzow, Lake Mills.

James C. H. Russell, 81 North Main Street, Fort Atkinson.

Alfred E. Leiser, 803 Twenty-second Avenue, Monroe.

Ann Bardeen, 1300 University Avenue, Madison.

Russell P. Sinaiko, 110 East Main Street, Madison.

Max M. Smith, 1300 University Avenue, Madison.

James H. Barbour, 930 Clymer Place, Madison.

Raymond H. Evers, Lake View Sanatorium, Madison.

Harold B. Haley, 524 East Gorham Street, Madison.

George Kumasaka, Milwaukee County General Hospital, Milwaukee.

Joseph A. Bartos, 1019 West Capitol Drive, Milwaukee.

William W. Kah, 716 North Eleventh Street, Milwaukee.

George J. Schroth, Milwaukee Hospital, Milwaukee.

Donald E. Winnik, 2715A North Forty-Eighth Street, Milwaukee.

David P. Halfen, Veterans Administration, Wood.

Louis D. Graber, Milwaukee County General Hospital, Milwaukee.

James R. Hurley, Veterans Administration, Wood.

Richard E. Lukes, 2820 North Forty-Seventh Street, Milwaukee.

Sidney M. Boxer, 1414 North Twelfth Street, Milwaukee.

William G. Arnold, 308 West North Avenue, Milwaukee.

Elvira Seno, Veterans Administration, Wood.

Paul S. Pierson, 2018 East North Avenue, Milwaukee.

Charles E. Schmidt, 231 West Wisconsin Avenue, Milwaukee.

Casper L. Berner, 3512 West Silver Spring Drive, Milwaukee.

Frank J. Pulito, 731 East Lyon Street, Milwaukee.

James M. Carter, 636 West Juneau Avenue, Milwaukee.

Clarence Y. Sugihara, Milwaukee County General Hospital, Milwaukee.

John W. Maxwell, 707A West Walnut Street, Milwaukee.

Jack A. End, 720 East Wisconsin Avenue, Milwaukee.

Edward C. Schmidt, 208 East Wisconsin Avenue, Milwaukee.

Michael F. Koszalka, Veterans Administration, Wood.

Changes in Address

C. S. Williamson, Albuquerque, to Tijeras, New Mexico.

O. W. Friske, Albuquerque, New Mexico, to 1302 West Flower, Phoenix, Arizona.

L. E. Gallett, Pulaski, 4148 Armitage Avenue, Chicago, Illinois.

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A complete line of laboratory controlled ethical pharmaceuticals.
Chemists to the Medical Profession for 44 years.
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THE SCIENTIFIC WAY...

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Leonard Gorenstein, Chicago, Illinois, to 425 East Wisconsin Avenue, Milwaukee.

DEATHS

Dr. William Van Zanter, 78, prominent Sheboygan physician and former Sheboygan County coroner, died on February 16 at a hospital in Sheboygan. He had practiced in that city since 1903.

The doctor was born in Allegan County, Michigan, on August 26, 1869. In 1902 he graduated from Milwaukee Medical College, now Marquette University School of Medicine. Early the following year he established his practice in Sheboygan. Although most of his years there were spent in private practice, he was associated for a time with the Sheboygan Clinic, serving as director for eight years. He also joined with his son, Dr. Wesley Van Zanten, and several other physicians in the establishment of the Van Zanten Medical Clinic.

Doctor Van Zanten was a member of the Sheboygan County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, three daughters, and a son.

J. S. EVANS

Dr. J. S. Evans, widely known professor emeritus of medicine at the University of Wisconsin Medical School, died February 3 at a Madison hospital. He was 72 years old. A member of the medical school faculty for thirty-five years, Doctor Evans served as chairman of the department of medicine until his retirement in 1945.

Born in Westchester, Pennsylvania on March 6, 1875, the doctor received his medical degree from the University of Pennsylvania School of Medicine in 1899, interning at Germantown Hospital and the University of Pennsylvania Hospital during the following year. He joined the University of Wisconsin faculty in 1908, and organized the clinical facilities and student health department. In 1910 he became an instructor of clinical medicine at the medical school and in 1924 was named professor of medicine.

Doctor Evans was certified by the American Board of Internal Medicine and was a fellow in the American College of Physicians. Made an honorary member of the State Medical Society in 1945, he also held membership in the Dane County Medical Society and the American Medical Association.

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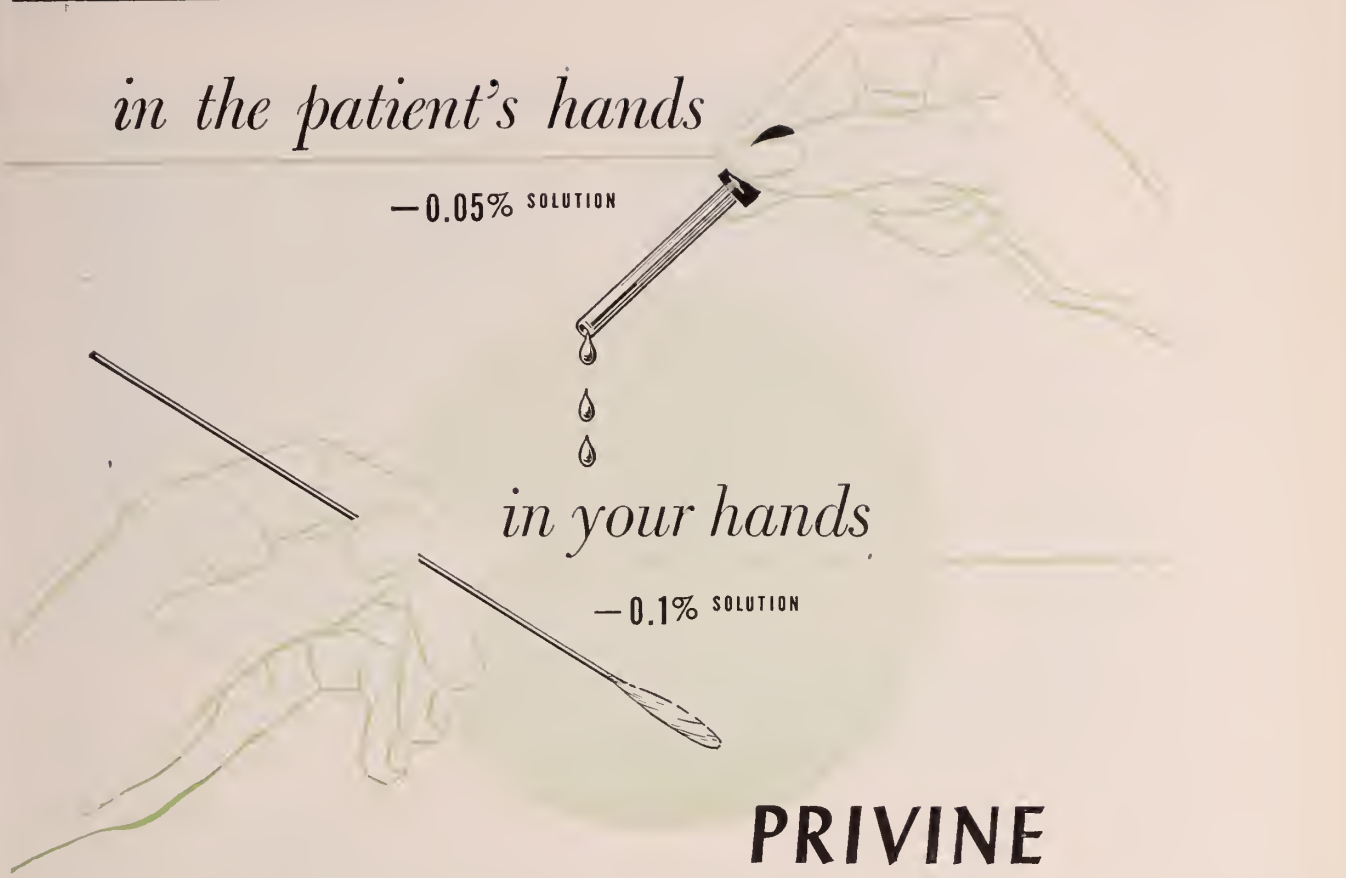

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520 N. Pinckney Street
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February 16, 1948

Dear Mr. Crownhart and Members of the Society: I desire to extend my great appreciation for the wonderful program put on by the State Medical Society and the State Board of Health on January 31, 1948, as I severed my official connection with the State Board of Health.

To have worked with the medical profession for some 47 years has been a privilege rarely extended to an individual. My relationship in all respects has been most pleasant and the courtesy extended to me as I traveled the state repeatedly was at all times an inspiration.

The reception that the Medical Society specially sponsored in the Loraine Hotel on the early evening of the 31st was a most enjoyable occasion. My regrets were that I could not meet all the people that were present.

My deepest appreciation and thanks are extended to you all.

Sincerely yours,
(Signed) C. A. HARPER, M. D.

MAYO CLINIC
Rochester, Minnesota
February 24, 1948

Dear Sir: Thanks very much for the *Wisconsin Medical Journal* and again permit me to congratulate you on the preparation of this issue.

I approached our own Council on the preparation of an issue similar to yours. There is something in the air but nothing definite has been decided. An issue with all the special instructions is certainly worthwhile to every member of a society.

Sincerely yours,
(Signed) A. W. ADSON, M. D.

Porter Building
Kansas City, Missouri
February 20, 1948

Dear Sir: May I take this opportunity of thanking you for your 1948 Blue Book issue of *The Wisconsin Medical Journal.* It seems to me to establish a milestone in state medical journalism, and certainly has a wealth of information which, in my opinion, could be well reviewed by all members of organized medicine.

The added distribution to the junior and senior medical students should serve to acquaint them with the work of the medical society, and instill a desire for them to become early associated with organized medicine, which is a condition much to be desired.

Again thanking you, I am

Very truly yours,
(Signed) JAMES R. MCVAY, M. D.

AMERICAN MEDICAL ASSOCIATION
February 26, 1948

Dear Sir: I received your Blue Book several weeks ago and also your letter of February 10, but I have had a series of meetings here and have not had time to look over the Blue Book until recently.

I think the book is excellent and contains an enormous amount of material for ready reference. It must have been quite a job to compile it. Congratulations.

With kindest regards, I am

Sincerely yours,
(Signed) GEORGE F. LULL

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Yours very truly,
(Signed) B. E. KUECHLE
Vice-President

MAYO CLINIC
Rochester, Minnesota
February 13, 1948

Dear Sir: I read the 1948 Blue Book issue of the *Wisconsin Medical Journal* with a great deal of interest. It is almost an encyclopedia in the amount of practical information which is made available, and it should be placed in the doctor's library for reference purposes. Furthermore, it demonstrates how well organized the Wisconsin State Medical Society is. Not alone is it well organized, but it is also well run. I don't see how the Blue Book could be improved upon; in fact, it should serve as a model for other state organizations. All power to you.

Sincerely yours,
(Signed) W. F. BRAASCH, M. D.

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Semi-Annual Report of the President

By MRS. A. W. HAMMOND
Beaver Dam

MRS. A. W. HAMMOND
Beaver Dam
1947–1948 President

IN HIS address before the members of the Conference of State Auxiliary Presidents and Presidents-Elect and National Chairmen of Standing Committees held in Chicago last November, Dr. Edward L. Bortz, president of the American Medical Association said, "The members of the Woman's Auxiliary are the greatest single asset the American Medical Association has."

As we approach the midway point of this fiscal year it is well that, as in the past, the members of this board look in retrospect upon their activities and, of still greater importance, with renewed vigor, with refreshened enthusiasm, and with greater vision meet the challenging tasks ahead. By so doing we can definitely evaluate our services to the State Medical Society of Wisconsin and can accentuate our objectives for the future. Thus we are able to determine whether we, here in Wisconsin, merit the distinction of being called the greatest single asset to the medical profession.

As your president I have performed the various routine tasks attendant this office. The answering of many letters has not been a "distasteful job" but instead a genuine pleasure, for through them I have become better acquainted with you. Thus the bonds of our friendship have been more tightly woven.

Visiting county auxiliaries has been one of my most stimulating and pleasurable experiences. To date I have been a guest of the Fond du Lac, Dane, Dodge, and Kenosha groups and have definite plans to meet with others.

In the very near future I am to represent the Auxiliary at a conference called by Governor Rennebohm to discuss the better care of the mentally ill in our state and county hospitals. It is most gratifying and encouraging to know that Governor Rennebohm is gravely concerned over the conditions existing in our state institutions and favors a program of better care such as our Auxiliary and State Medical Society are endorsing.

To have a better knowledge of the care some of the mentally ill are receiving I have accepted an invitation to make a tour of the two hospitals here in Milwaukee tomorrow.

On November 6 and 7 I attended the fourth annual Conference of State Presidents and Presidents-Elect and National Chairmen of Standing Committees held at the La Salle Hotel in Chicago. To greet former friends and to meet new ones was a joy. To hear of the projects in their own auxiliaries and to discuss mutual problems with them was indeed an inspiration. To listen to the highly stimulating talks of the members of the Board of Directors of the American Medical Association was an enviable and unforgettable experience.

This morning we have held the second School of Instruction, with the hope that it has proved beneficial to the leaders of tomorrow in our Auxiliary. Our reports this afternoon will reveal the progress

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made toward the goals set for this year, namely: (1) to be well informed, (2) to be vigilant, and, (3) to be friendly.

There are two activities that Mrs. Eustace A. Allen, our national president, is stressing at the request of the Advisory Council this year. They are public relations and organization.

I am convinced that some sort of a Laity Day is mandatory on the program of every county auxiliary. The expansion of our membership by the reactivating of auxiliaries that have disbanded and by the organizing of new ones is another must on our program. I would like to see our efforts to carry out these objectives in our state accelerated and thus keep apace with the national endeavors.

In addition to these two nation-wide auxiliary projects, there are two others here in Wisconsin demanding our efforts.

First, our interests in the procurement of better care for the mentally ill in our state and county hospitals must be constant. This year we have an opportunity to continue to study the needs of these institutions and to carry out an educational program that will enlighten the public about these needs. In this way the groundwork will be laid for exerting our influence in the appropriating of sufficient funds for this care when the budget for 1949 is drawn up by our legislators.

Secondly, because of the still very acute manpower shortage in the field of nursing, a profession closely affiliated with our own, the nurse recruitment program should have our energetic support.

The stressing of these four activities does not mean the subordination of our other responsibilities, but rather it means intensive action to meet problems of immediate exigency.

SOCIETY PROCEEDINGS

Brown—Kewaunee—Door

The January meeting of the Auxiliary to the Brown–Kawaunee–Door County Medical Society was held at the home of Mrs. Glen Denys. The Woman's Club chorus of De Pere presented a musical program. This was the annual meeting, and officers for the year were elected.

Dane

The January meeting of the Auxiliary to the Dane County Medical Society was at Baron's tea room. Bridge followed the business meeting. On February 9, a luncheon meeting was held at the Park Hotel. The speaker for the afternoon was Prof. Helen White of the English Department of the University of Wisconsin. Dane County was honored by the presence of Mrs. A. W. Hammond, state president of the Auxiliary and several others from her home county.

Fond du Lac

Mrs. J. F. Twohig entertained in January at a dinner meeting for the Auxiliary to the Fond du Lac County Medical Society. This was the philanthropic meeting of the year, and the evening was spent in working on a project adopted by the group to bring cheer to patients in the sanatorium. A brief business meeting was conducted by the president, Mrs. E. H. Pawsat.

La Crosse

On Wednesday, January 28, Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, addressed the Auxiliary to the La Crosse County Medical Society at a 7 o'clock dinner at the Stoddard Hotel. His subject was "The Health Challenge In Our Schools." The superintendents of the public and parochial schools and the principals of the high schools were invited. Doctor Bauer was entertained at a small reception following the dinner.

Milwaukee

The January meeting of the Auxiliary to the Medical Society of Milwaukee County was held at the Knickerbocker Hotel. Members heard the Rev. Henry Gerecker, chaplain of the United States Disciplinary Barracks in Milwaukee discuss "My Personal Observations at the Nuremberg Trials."

A study group met on the same day to discuss the Wagner–Murray–Dingell Bill.

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Manitowoc

The November meeting of the Auxiliary to the Manitowoc County Medical Society was held at the home of Mrs. R. G. Yost. At the business meeting, it was voted to finance the sending of *Hygeia* to Lincoln High School, Manitowoc Junior high schools, and all county high schools.

The members were entertained by members of the Monday Music Club.

In December a luncheon meeting was held at the Hotel Manitowoc. Mrs. Norman C. Erdman, president of the Auxiliary, initiated the plan to donate fiction books to the new nurses home at the Holy Family Hospital, and members voted to accept the plan.

Mrs. Harry Pehrson entertained with the singing of Christmas carols.

Sheboygan

The first meeting of the year of the Auxiliary to the Sheboygan County Medical Society was held at the home of Mrs. J. W. McRoberts. The speaker for the afternoon was Miss Florence Finger, supervisory nurse of the City Health Department. She told how auxiliary members could assist the health program for the community. Gifts for the veterans at Wood Hospital were brought to the meeting.

The December meeting was held at 1 o'clock luncheon at the Wegner Heidelberg Club. An interesting talk was presented by John Magalee, Hindu from British Guiana. He is in the United States to obtain a medical education preparatory to becoming a medical missionary in his native land.

A business meeting followed, at which time a fruit cake contributed by Mrs. Ludwiz Gruenewald, specially made from an old German recipe, was offered to members of the group, proceeds going to the Card fund. Christmas gifts were exchanged.

In January the members met at the Cottage Tea Room. Mrs. Frank Stroub presented the history of "The Marshall Fields: A Study in Wealth" by John Treball.

Washington—Ozaukee

Members of the Auxiliary to the Washington–Ozaukee County Medical Society were entertained in December by their husbands at the Republican Hotel.

Following a dinner and program, the Society and Auxiliary held separate meetings. Mrs. E. L. Bernhardt, West Bend, succeeded Mrs. C. P. Kauth, Port Washington, to the presidency

In January the meeting was held at the Elks Club; the guest speaker was Mr. E. A. Clemans. His subject was "How We Became A State."

During the business meeting, the Society voted to support the mobile chest x-ray unit as one of its projects. They also voted to donate $5.00 to the March of Dimes. Each Auxiliary member was urged to seek donors for the Oshkosh civilian blood bank.

Mid-Year Conference

The mid-year Conference of the State Auxiliary was held Wednesday, February 4, at the Hotel Schroeder in Milwaukee. In the morning the school of instruction was held, the purpose of which is to train members for leadership. In the afternoon, reports of state chairmen and county auxiliaries were given.

Dr. W. D. Stovall, the president of the State Medical Society, was guest speaker at the noon-day luncheon. His subject was "Wisconsin Physicians Service."

The Auxiliary was honored by the presence of the president of the National Auxiliary, Mrs. Eustace A. Allen.

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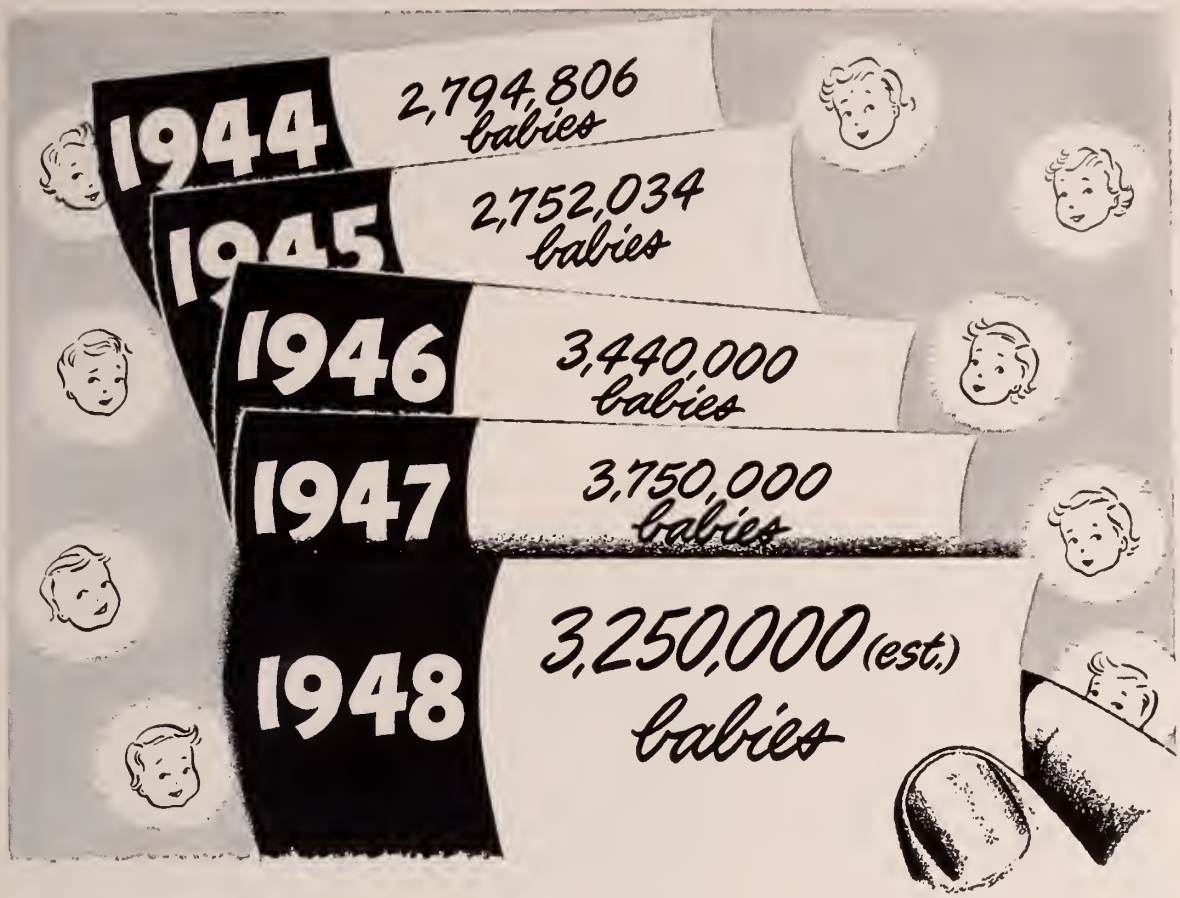

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Communal Sick-Care in the German Ghetto. By Jacob R. Marcus, Ph. D., Adolph S. Ochs Professor of Jewish History, Hebrew Union College. Cincinnati: The Hebrew Union College Press, 1947. Price $2.50.

This is an excellent text concerning problems which are of considerable significance to society even today. In the preface the author states as the purpose his attempt to describe Jewish communal care of the sick in German lands of the medieval period. The author takes one back to the problems of sick care in the seventeenth century as they related to Jewish folk. The organizations which were set up by the Jewish communities are discussed, and their methods of raising funds for the care of the sick are described. Health was of the greatest interest, and careful supervision was provided. The fees for their physicians' services were paid by the sick care organizations, and detailed instructions were formulated for the physicians' direction. Plague was one of the serious diseases of that earlier day, and it brought problems to the Jewish community, particularly in reference to increasing the pay of physicians and attendants during such times in an effort to be assured of medical service. Mention is made of periods when Jewish physicians were forbidden to practice in certain of the large communities. Questions concerning fees were apparently a constant source of friction. The German Hebra Kaddisha in the sixteenth century was an organization to care for burials in times of crisis because of the unusually high costs of burials by regular agents who took advantage of such occasions. As a natural sequence these brotherhoods took over more functions in relation to health and disease of the Jewish population.

The text is filled with references and footnotes for those who care to make more detailed studies, and it is very revealing to see how an ingenious Jewish

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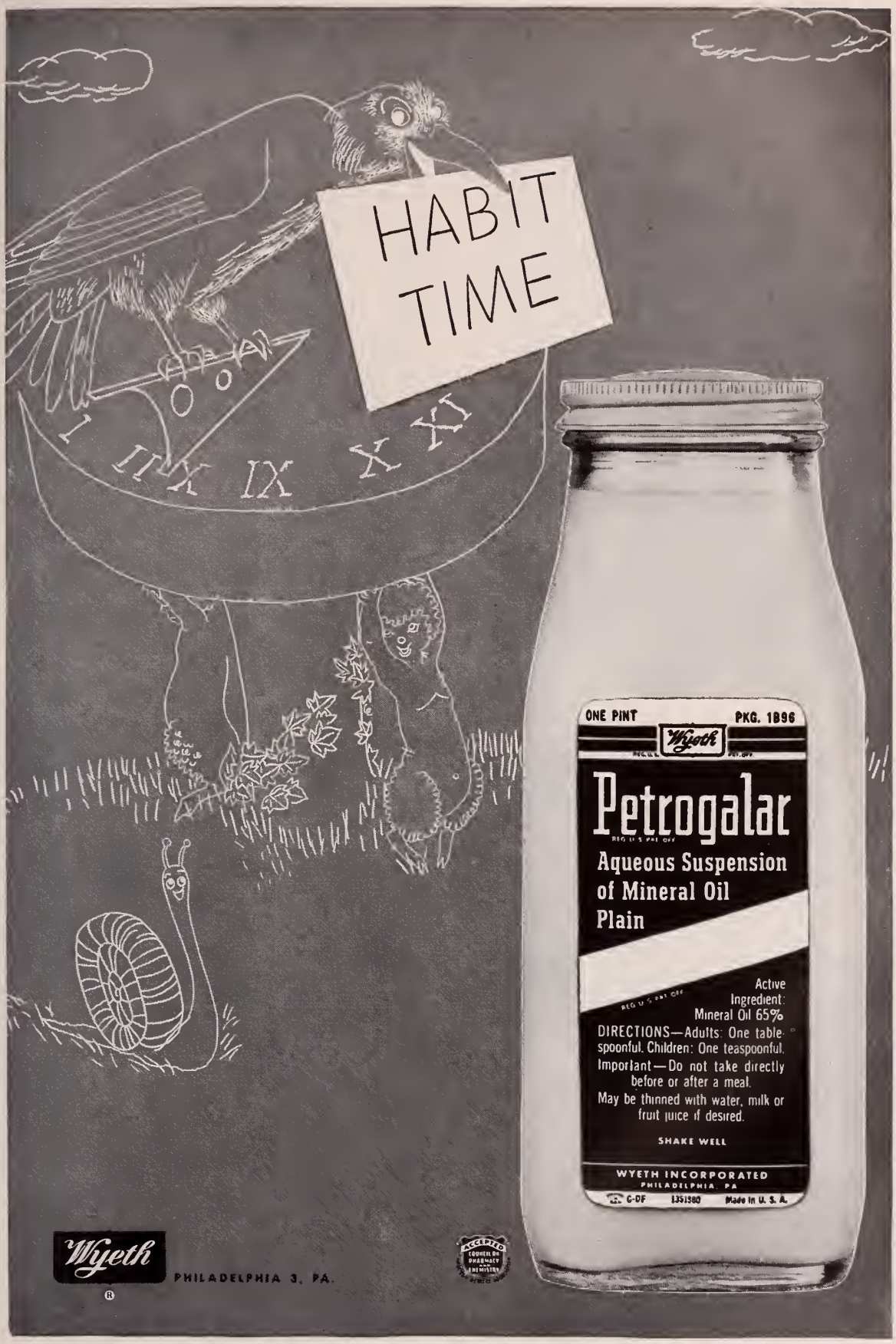

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population living in the German Ghetto was able to look after its own health problems in such a satisfactory fashion. This deserves widespread study by groups wishing to organize health plans for their membership, and it gives a much clearer insight into problems which the Jewish folks faced in these earlier days and which are intensified today in many of the larger foreign cities of Europe. The material is well written and a very adequate bibliography is supplied.—L. R. C.

Skin Manifestations of Internal Disorders (Dermadromes). By Kurt Wiener, M. D., Dermatologist, Mount Sinai Hospital, Deaconess Hospital, Saint Michael's Hospital, Milwaukee, Wisconsin. Pp. 690, with 386 text illustrations and 6 color plates. St. Louis: The C. V. Mosby Company, 1947.

In a review of 3,110 references the author has given us a current systematic presentation of the skin manifestations of internal disorders. This has resulted in a lengthy book which gives information not only of the systemic symptoms of disease but also of the dermadrones (literally, fellow-traveler on the skin). The author rightfully laments the little attention paid in the modern period of objective laboratory methods to the skin as a diagnostic and prognostic aid.

The book has 43 chapters which give the dermadrones of systemic infections, of parasitic diseases, of the granulomas, of metallic poisoning, of different physiologic states, and of the psychoses. The descriptions of the various conditions are brief; the references are presented in full title; both fact and disputed matters are given; the illustrations are numerous and the few kodochromes are excellent. There are seven well compiled tables at the end of the book which differentiate the exanthems, the diffuse and yellow pigmentary disturbances, the hypertrichoses, the skin normals of different age groups, the hemorrhagic diseases, and the causes of pruritus.

The author has completed a praiseworthy task and has carefully refrained from describing conditions as dermadrones which are purely cutaneous. The index and text are quite complete. Histoplasma is a noteworthy omission. The book is excellent and is recommended to dematologists, internists, and general practitioners.—S. A. M. J.

Ulcer; The Primary Cause of Gastric and Duodenal Ulcer; Diagnosis, Medical and Surgical Treatment, Prevention. By Donald Cook, B. A., M. D. Pp. 192, with 27 illustrations. Chicago: Medical Center Foundation and Fund, 1946.

"The theory of the Primary Cause of gastroduodenal ulcer states that there is an ulcer-bearing area of the stomach and of the duodenum which comprises that portion of these organs which may be pinched, rubbed or pressed between the posterior surface of the liver and the ventral surface of the spine and prevertebral structures." This statement summarizes the purpose of the book. The author theorizes as to the cause of ulcer and attempts to establish as fact his theory. His hypothesis is interesting but unconvincing. In addition, he has presented a review of gastroduodenal ulcer. There are other better treatises on the subject.—K. L. P.

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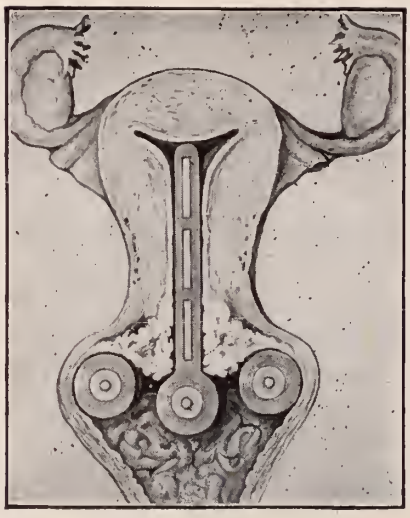

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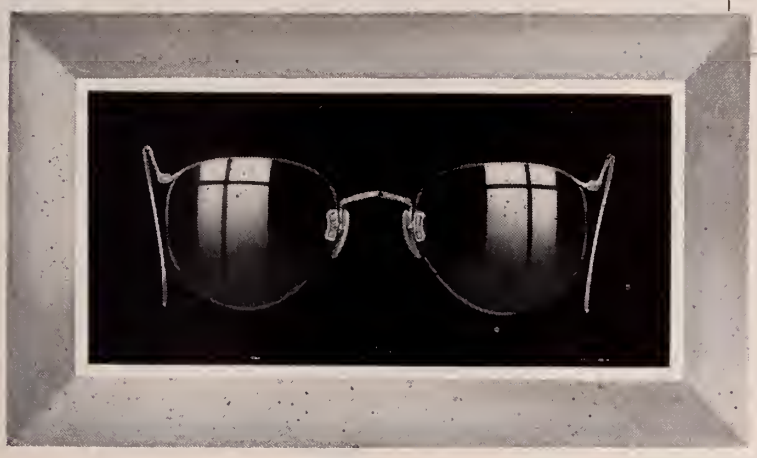

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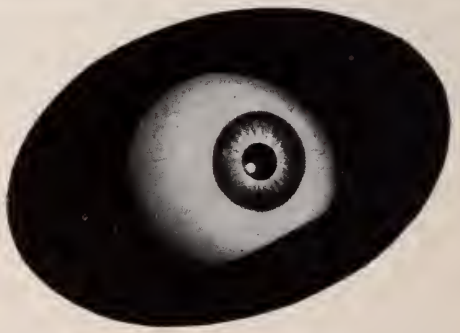

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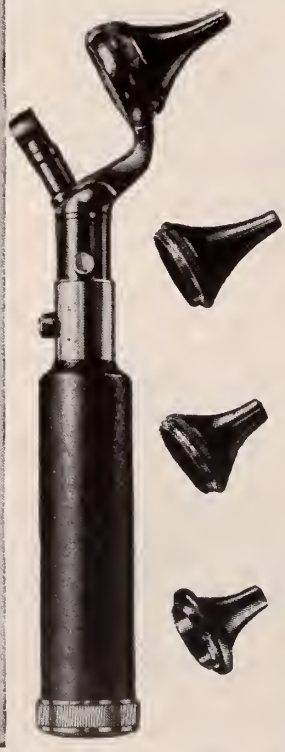

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2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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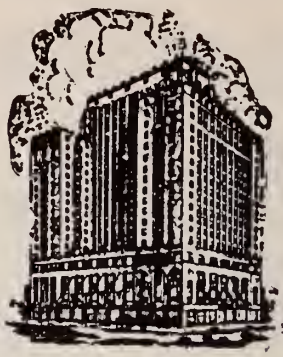

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*Barr, Joseph S., *Ruptured Intervertebral Disc and Sciatic Pain*, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	343
American Meat Institute	285
American Optical Company	350
Ar-Ex Cosmetics, Inc.	328
Ames Company, Inc.	352
Audiphone Utilities	355
Ayerst, McKenna & Harrison, Ltd.	283
Barlow–Maney Laboratories	335
Barr X-Ray Company	328
Benson Optical Company	348
Bergmann Prescription Center	323
Bilhuber–Knoll Corporation	273
Borden Company	337
Burroughs Wellcome and Company	331
Camel Cigarettes	351
Camp, S. H. and Company	274
Central Drug	338
Ciba	275, 329
Cook County Graduate School of Medicine	350
Doerflingers	336
Drekmeier Drug	323
Eaton	276
Endocrine Laboratories	344
First Central Dispensary	323
Hotel Schroeder	352
House of Bidwell	328
Hurley X-Ray Company	355
Ivanhoe Treatment, Inc.	359
Jensen Brothers Prescriptions	338
Kennedy–Mansfield	354
Lakeside Laboratories	278
Lilly, Eli and Company	facing page 287
Lov-é Brassieres	282
Luzier's Cosmetics, Inc.	353
M & R Dietetic Laboratories	349
Mallatt Pharmacy	323
Massachusetts Protective	350
Mather Pharmacy	338
Mayer Drug	338
Mead Johnson and Company	280, 358
Medical Protective Company	342
Milwaukee Optical Company	344
Milwaukee Sanitarium	360
Nechin, A. R. Company	327
New World Life Insurance Company	348
New York Polyclinic	336
Orthopedic Appliance Company	355
Page Milk Company	325
Parke Davis and Company	270, 271, 284
Philip Morris	277
Physicians and Hospitals Supply	341
Physicians Casualty Association	355
Physicians Radium Association	352
Pogue, Mary E. School	334
Prescription Pharmacy	323
Radium Emanation Corporation	346
Radium Service Corporation	355
Rennebohms	323
Rentschlers	354
Rexair	333
Rexall	345
Riggs Optical Company	272
Rogers Memorial Sanitarium	360
Sacred Heart Sanitarium	340
St. Croixdale Sanitarium	273
Schering	321
Schlintz Bros. Drug Store	338
Searle, G. D. and Company	317
Shorewood Hospital Sanitarium	323
Smith–Dorsey Company	286
Smith, Kline and French	319
Spencer, Inc.	356
Squibb	279
Summit Hospital Sanitarium	346
Uhlemann Optical Company	347
Winthrop–Stearns, Inc.	281
Wyeth	339
Zemmer Company	326

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923

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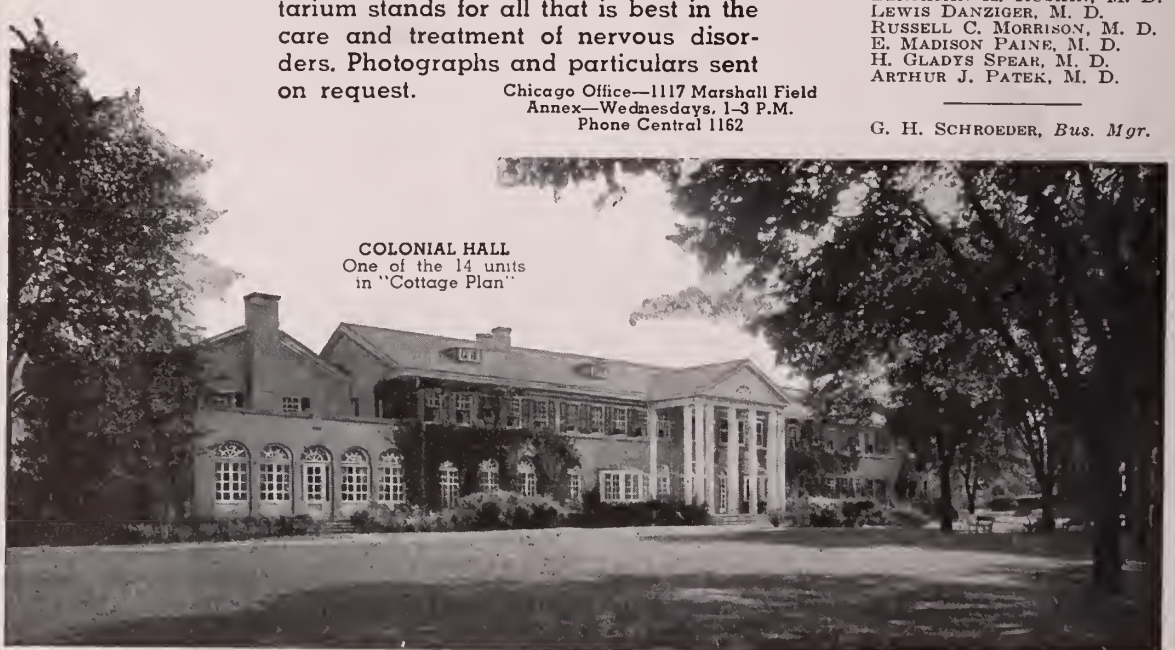

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IN THIS ISSUE

PSYCHIATRY AND THE GENERAL PHYSICIAN
By D. W. Hastings, M. D.

HISTAMINE IN CERTAIN TYPES OF HEADACHE
By Samuel Salinger, M. D.

RINGWORM OF THE SCALP
By Donald M. Ruch, M. D.

RESEARCH PROJECT ON APPENDICITIS IN ROCK COUNTY
By Thomas J. Snodgrass, M. D., Wayne A. Munn, M. D. and Thomas Flarity, M. D.

THERAPY IN ACUTE INFECTIOUS DISEASE IN CHILDREN
By J. P. Conway, M. D.

COMMENTS ON TREATMENT

NOTES ON CLINICAL PATHOLOGY

TABLE OF CONTENTS, PAGE 364

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Psychiatry and the General Physician, by D. W. Hastings, M. D., Minneapolis	379
Histamine in Certain Types of Headache, by Samuel Salinger, M. D., Chicago	382
Ringworm of the Scalp; Review of 100 Cases, by Donald M. Ruch, Milwaukee	385
Research Project on Appendicitis in Rock County, by Thomas J. Snodgrass, M. D., Janesville; Wayne A. Munn, M. D., Janesville; and Thomas Flarity, M. D., Beloit	388
Therapy in Acute Infectious Disease in Children, by J. P. Conway, M. D., Milwaukee	395
Comments on Treatment	399
Notes on Clinical Pathology	406
As It Looks to Your State Board of Health	407

EDITORIAL

This Partnership, by Mr. O. T. Jacobsen, Racine 405

MISCELLANY

	Page
The President's Page	400
As It Looks From the Blue Cross Viewpoint	401
Two Important Publications for Benefit of SMS Members	403
Spring Clinics	408
Society Proceedings	409
News Items and Personals	412
And About the Third and Twelfth Districts	414
Society Records	416
Deaths	418
Correspondence	420
The Woman's Auxiliary	422
The Journal Bookshelf	424
Coming Events	432
Trade News	436
Index to Advertisers	439
Physicians' Exchange	440
List of Executive Officers of County Medical Societies	441

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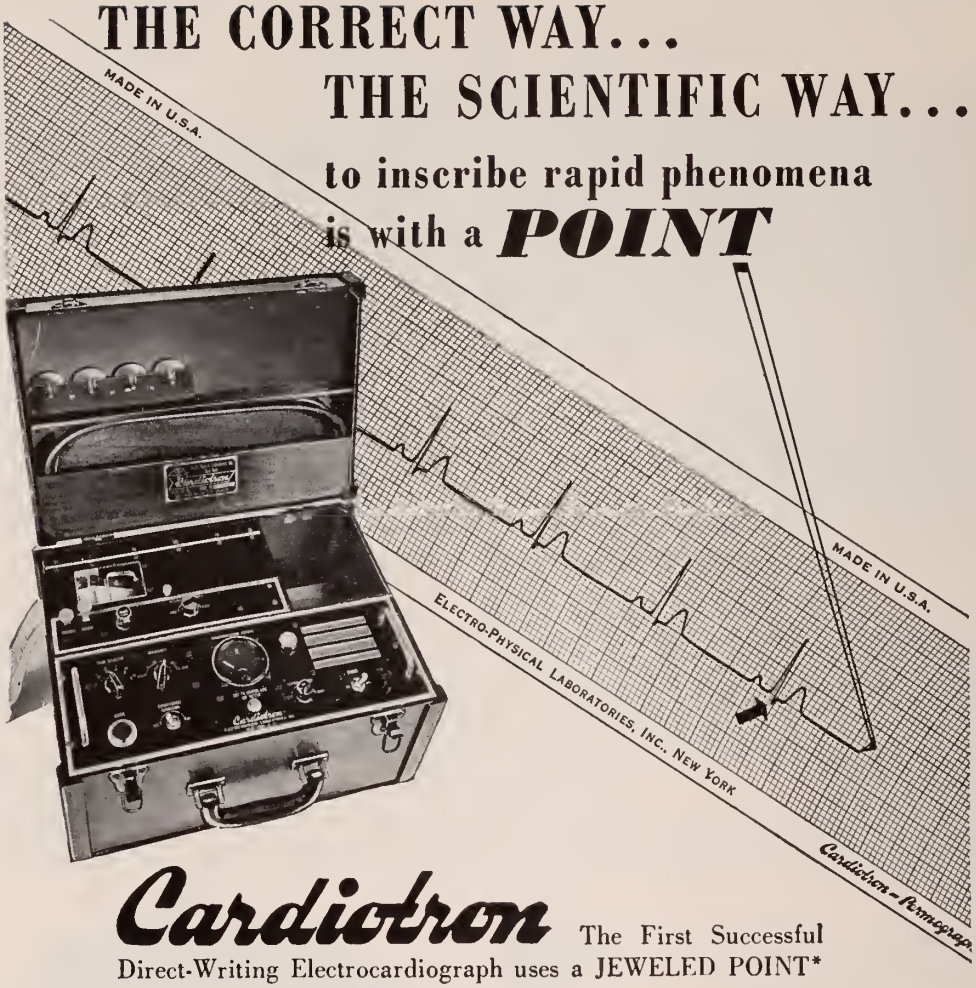

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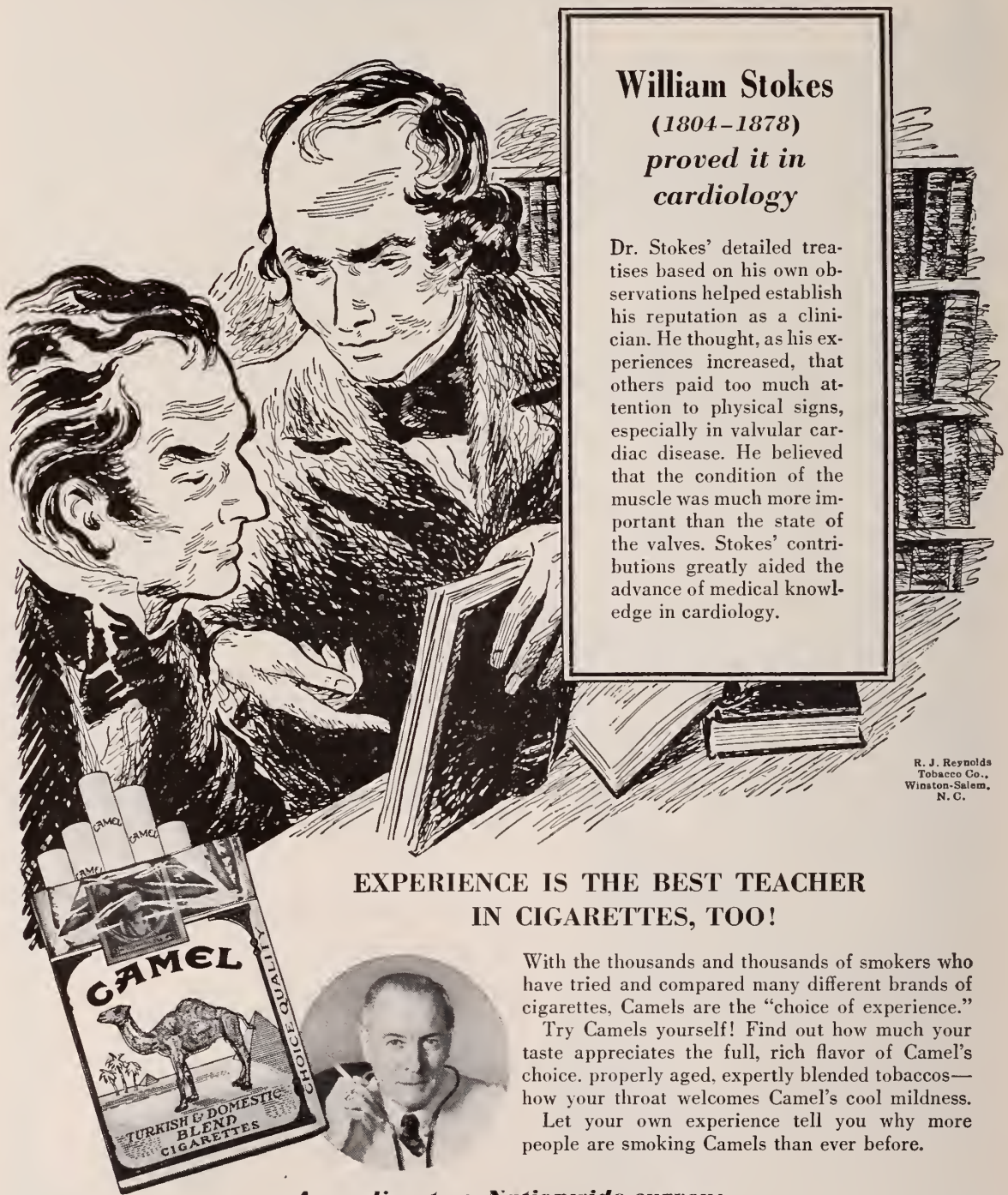

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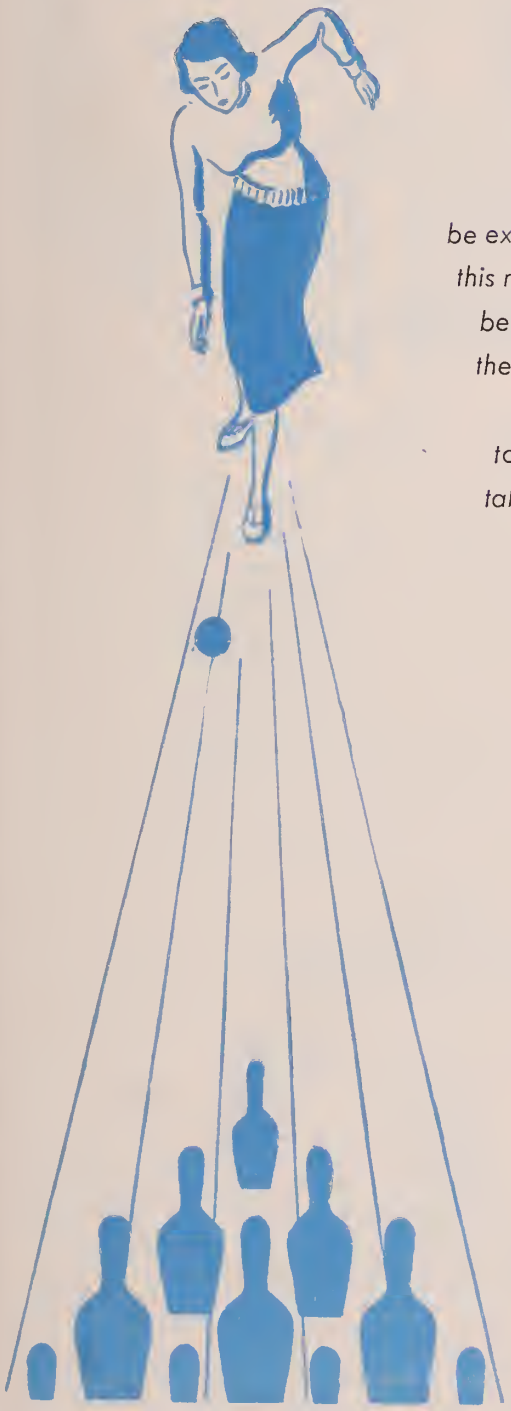

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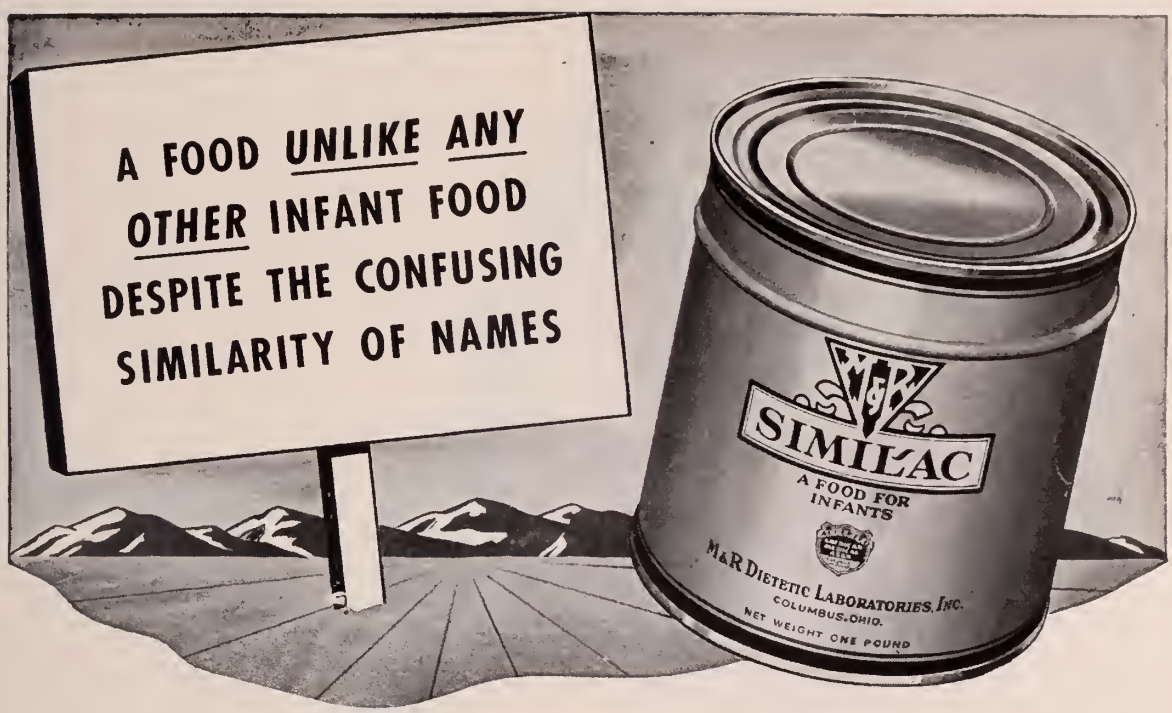

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1. Arbesman, C. E. et al. Jl. of Allergy 17:275, Sept. 1946.
2. Fuchs, A. M. et al. Jl. of Allergy 18:385, Nov. 1947.
3. Feinberg, S. M. and Friedlaender, S. Am. J. Med. Sci. 213:58, Jan. 1947.

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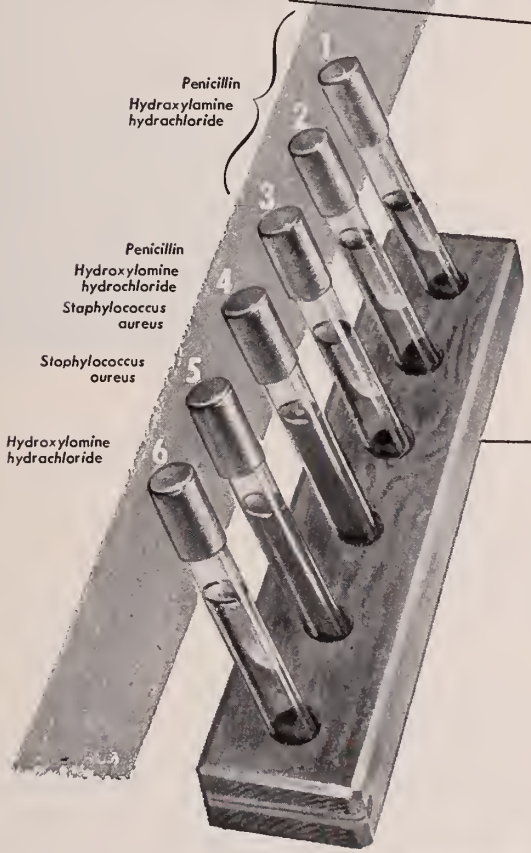

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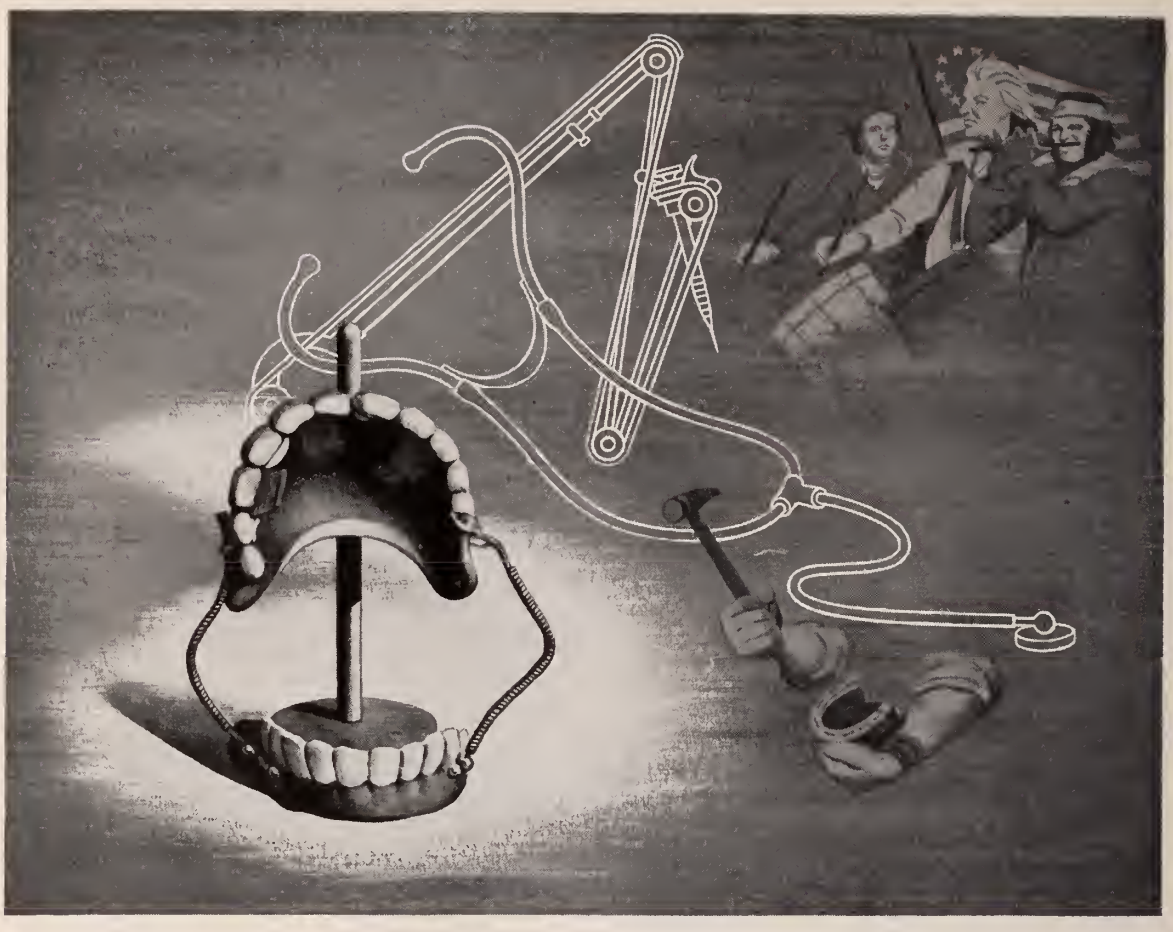

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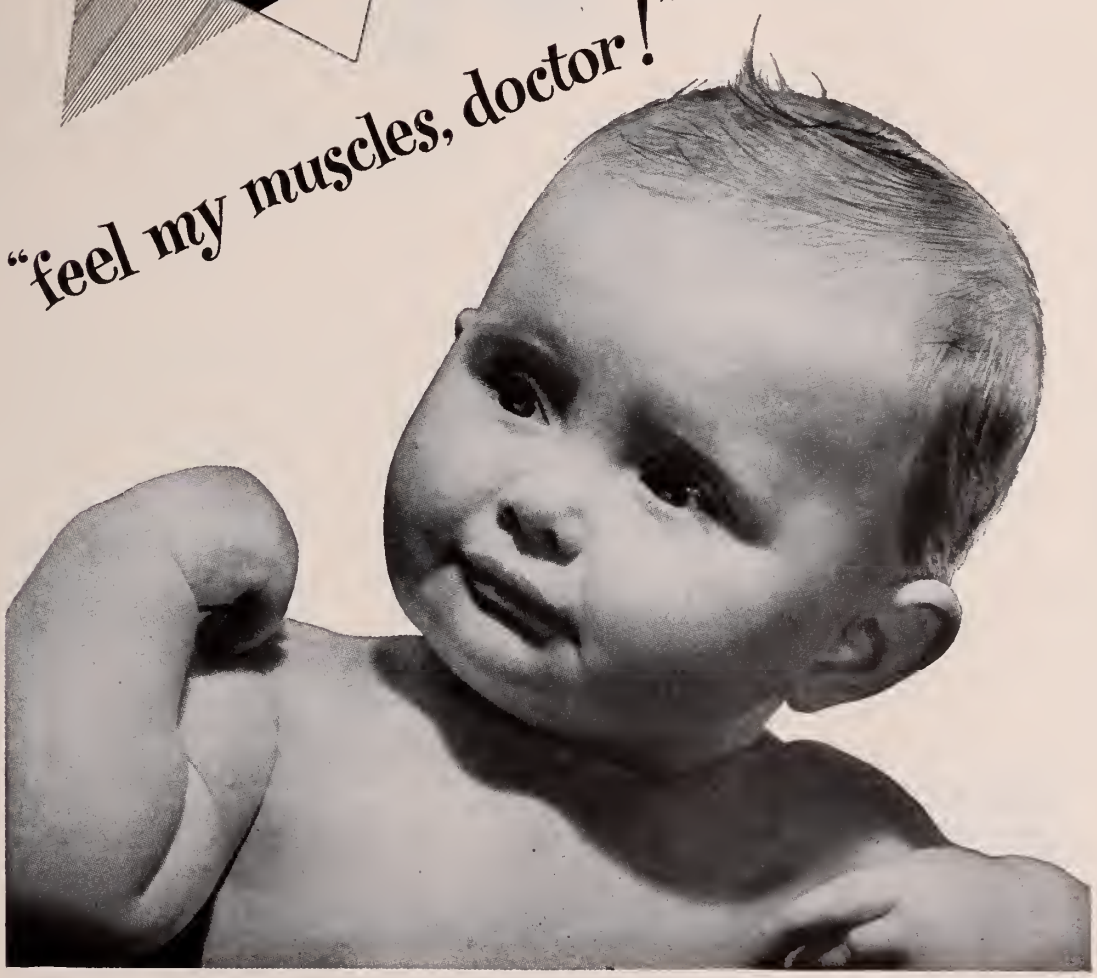

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Psychiatry and the General Physician*

By D. W. HASTINGS, M. D.
Minneapolis

D. W. HASTINGS

Formerly chief psychiatrist of the Army Air Forces Doctor Hastings now holds the position as professor and head of the department of psychiatry and neurology at the University of Minnesota Medical School. The doctor was born in Madison and graduated from the University of Wisconsin Medical School in 1934. Prior to his entering military service, he spent a year as psychiatrist at Harvard University and a period as clinical director of Pennsylvania Hospital in Philadelphia.

SOMEWHAT over a year ago at Minnesota, there was conducted one of the most interesting teaching experiments in which I have had the good fortune to participate. Sponsored by the Commonwealth Fund, for two weeks twenty-five general physicians and eight or nine internists and psychiatrists lived together in the same building and exchanged ideas, held classes and lectures, examined patients, and discussed their various illnesses from the standpoint of the patient as a total person and personality. In listening to these general men discuss their practices, one of the points which was of particular interest to all of us was the high percentage of psychosomatic disorder which the general physician is called upon to deal with in his day in, day out practice. The estimates ran from 30 to 80 per cent, with the mean falling in the neighborhood of about 50 per cent. Thus, if this was a representative group of doctors in general practice—and I believe it was—almost half of such a doctor's practice will consist not of the treatment of organic illness as the primary medical problem but of the treatment and management of the patient whose prime difficulty lies in the emotional sphere and whose emotional problems are reflected in his physical well-being. You are all better acquainted than I with the patient who complains of palpitation and shortness of breath, the patient who complains of backache or of headache, or who has various digestive complaints, but in whom there are no positive physical or laboratory findings to explain the trouble and in whom the doctor, assuming that his training has led him to recognize such disorders, suspects or knows that emotional turmoil of one sort or another lies at the root of the illness.

From these statistics we can draw a conclusion which appears to be true, namely, that the general physician is the first and most important line of defense in attacking this medical problem which is of such huge proportions. That the psychiatrist is interested in the general physician becomes an understatement, since the psychiatrist must realize that the greatest share of psychotherapy, if it is to be done at all by medical men, must be done by the general physician as he sees these patients in his own community. Certainly there are not enough psychiatrists to carry this staggering load, and I hope there never will be. It is my strong opinion that most of these patients can be handled better by the well trained general doctor, seeing the illness in its early phases as a rule, than they can be months or years later by even the most adept psychiatrist. I would like to venture a guess that this phase of medicine will become the chief calling of the general physician in years to come. Here will be an area in which he will be the specialist, and a specialist of the most special kind, if one measures results by the help which the doctor can give to a suffering person.

It might be of interest to review with you some of the concepts which are fundamental as one thinks of the patient whose symptoms are on an emotional basis. It has long been known that the entire body reacts as a unit, that physical diseases, infections for example, may and do produce emotional symptoms, and that in turn strong emotions such as anger, rage, hatred, anxiety, love, and so on produce physical or physiologic symptoms. The physical reflections of emotion were first studied by laboratory methods by Dr. Walter Cannon of this country and in a somewhat less direct manner by Pavlow. Cannon described how strong emotional tones altered the body's physiology, did it consistently and to measurable degrees. These concepts and findings are important to keep in mind as one deals with psychosomatic problems. If we grant that emotions produce physical or physiologic responses, such as increased heart rate, increased minute volume output, peripheral vasospasm or vasodilatation, hyperperistalsis or hypoperistalsis or increased urinary out-

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

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put, to mention only a few, the next step which must attract our attention is what produces these emotional states in our patient, a human being. In passing let me call to your attention that the patient does not come to the physician complaining of increased heart rate or increased minute volume output, but puts it in much more terse language. "My heart hurts," "My heart skips beats and turns flips," "My heart races and I am afraid I have heart trouble," "My heart pounds and I get dizzy" is the language of the patient as he describes the physical reverberations of anxiety, to pick out several common complaints located in the cardiovascular system.

To return to the cause of these emotions, one thinks in general in the following terms: These symptoms, the physiologic symptoms of emotion (and this is what is usually meant by the term "psychosomatic") are produced by anxiety or tension, and a good many patients of this sort have open anxiety or tension if you ask about it. Behind the anxiety or tension lie conflicts in the person's life—opposing emotional forces fighting for recognition. Let me illustrate with a simple case. A man of 28 comes complaining of his heart pounding and some dizziness. These are his psychosomatic symptoms. He has feelings of anxiety in the form that he fears he has heart disease and may die. (He may not express this anxiety unless you ask him.) Physical and laboratory examinations show nothing very pertinent, and the nature of the condition makes you suspect that his trouble is in the emotional realm. We now can apply our formula of conflict to anxiety to psychosomatic symptoms and know that we must try to find what conflicts exist in this man to produce the anxiety and thus the symptoms. In this particular case psychologic investigation showed that he was married four years ago, that his wife is alcoholic and a source of embarrassment to him and a detriment to him professionally (he happens to be a lawyer), and that their only child, a boy of 3, has a rather marked intellectual defect. His symptoms date back about one year, roughly around the time he began to realize that his child was not like other children. However, we still have not answered specifically why this man is in trouble. Specifically he is in trouble, first because of marked feelings of anger and hostility to his wife, amounting to hatred which he could not admit even to himself until he had the opportunity to talk and think it through. However, he was able to manage these feelings, to erect fences around them if you will, until the time that the child's difficulty became apparent. This served to mobilize his hostile aggressive feelings against both the wife and the child, holding the wife responsible for the feeble-minded child, in turn holding the child responsible for the necessity of continuing the marriage to a sick wife. Why these strong emotional feelings selected the cardiovascular system as their theater I cannot tell you, but, in any event, his illness now becomes understandable and one is able to see the state of conflict in which this man is. I wonder if it would have done this patient any real good only to reassure him that his heart was sound or to give him quinidine for these attacks or to have put him on a sedative of some type. These might well have helped in an adjunctive manner, but certainly the main problem with him lies in the viewing of him as a total person functioning or trying to function in his own particular environment.

Weiss and English have classified all patients who come to physicians into three groups:

I. The patient with organic disease and without any pertinent emotional component.
II. The patient whose illness is on an emotional basis and without any pertinent organic findings.
III. The patient whose illness is composed of both organic and emotional elements.

These writers estimate that each group is of approximately equal size, that is, that approximately one-third of all patients fall in each group. Here again is further information that approximately one-half of a doctor's practice is made up of psychogenic illness. The lead article in the *Journal of the American Medical Association* of August 30, 1947, by Dr. Joseph Wearn also contains a similar percentage.

If these are true facts, and realizing that the general physician is the most important line of medical defense in meeting this medical problem, whether he practices in a small community or a large one, we must next turn our attention to the capabilities of the general physician as he sees and treats these patients. Here we meet the hard fact that most physicians now in practice have never received any formal training in the principles and practice of office psychotherapy. This is not the fault of the doctors, but rather the blame rests with us who are in the medical schools for never having taught these technics to medical students, technics which are definite, readily understood, and usable by the doctor as he deals with the reality of medical practice. Some few physicians seem to come by these technics intuitively and based on their natural spontaneous feelings for the patient as a person. But by analogy, I imagine some few men can intuitively come by surgical technics without formal training. However, it is generally agreed in both fields that a certain amount of training is of help. Without laboring the point, the fact is that most doctors have had excellent training in the various organic ailments but practically no training in a field which will equip them to deal effectively with what seems to be about half of their patients.

I know of no immediate solution to this problem except by postgraduate training (which is too seldom available in this field) and by study of the pertinent literature, and there are several good texts. One is by the two authors I just mentioned and is well worth the reading of every physician,

whether he be a general physician, psychiatrist, surgeon, or ophthalmologist. I believe this type of knowledge is so basic that at Minnesota we utilize this particular book as a text in the psychiatric course for freshmen medical students.

I like to think of two broad advantages which come to the general physician in particular and to all physicians in general upon having some grasp of the basic knowledge and facts of psychiatry as related to psychosomatic disturbances.

In the first place, and for want of a better term, I shall call this the diagnostic aspect of the problem. The physician who understands some of these basic concepts is in a much better position to abide by the first precept of medicine: "First of all, thou shall do no harm."

To return to the so-called diagnostic aspect of the problem, the physician who has a grasp of some of these principles and has an interest in his patients as whole people is in a much more comfortable position with his patients. He is able to make a positive diagnosis of psychosomatic disorder and is no longer baffled and frustrated when he has examined his patient and finds no relevant organic findings to account for the symptoms which brought the patient to him. He no longer feels compelled to follow the will-o'-the-wisp in endlessly searching for some evidence of organic disease to explain to himself what is wrong, nor does he feel it necessary to attempt to explain all the patient's symptoms on some accidental organic finding which in his heart he knows probably does not and could not cause the symptoms which the person is suffering. That the patient gains from such an understanding on the part of the doctor is obvious. Not only is the patient spared a continuation of the search for a nonexistent organic disease, but he is now put in a position wherein his problem is correctly diagnosed. At this point, if the physician does not have the training or the time to actually treat the patient by psychotherapeutic measures, at least no damage has been done, and both the doctor and the patient are correctly oriented in the realities of the particular illness this patient has and progress can be made by referring the patient to another physician, not necessarily a psychiatrist, who does this type of practice. Thus from a purely diagnostic point of view, both the doctor and the patient have gained: the doctor is more comfortable and has the knowledge he has done a good medical job, and the patient is benefited by being correctly diagnosed and steered into proper channels.

Along this same line, I cannot miss the opportunity of reading to you a pertinent statement written in 1884 by Clifford Allbutt, the great English clinician (quoted by Weiss and English): "A neurotic woman seems thus to be peculiarly unfortunate. However bitter and repeated may be her visceral neuralgias, she is told either that she is hysterical or that it is all uterus. In the first place she is comparatively fortunate, for she is only slighted; in the second case she is entangled in the net of the gynecologist, who finds her uterus, like her nose, is a little on one side, or again, like that organ, is running a little, or it is as flabby as her biceps, so that the unhappy viscus is impaled upon a stem, or perched upon a prop, or is painted with carbolic acid every week in the year except during the long vacation when the gynecologist is grouse-shooting or salmon catching. Her mind thus fastened to a more or less nasty mystery becomes newly apprehensive and physically introspective and the morbid chains are riveted more strongly than ever. Arraign the uterus, and you fix in the woman the arrow of hypochondria, it may be for life." I hope those of you who are gynecologists will forgive my using this excerpt, since no special arrows in your direction are intended. Times may have changed since 1884.

In the second aspect of this problem, which I shall call the treatment aspect, it would, of course, be ideal if all general physicians as well as all other doctors, too, were trained sufficiently in these matters so that the physician first consulted by the patient could handle these problems without the necessity of referring any great share of them to someone else. It is the first doctor, especially if he be the family physician, who often can do the most, and in the setting of the patient's own environment. And a great share of these situations are not difficult to treat. The doctor with the ability to listen patiently, who is interested in the patient as a person, who maintains the same objective attitude toward emotional illness as he does toward organic illness, who does not judge the patient on moral grounds, and who can maintain a warm friendly relation with his patients can do a good deal in the reasonably acute mild problems of this type, especially if they are largely based on real situations in the patient's recent life. The general physician without some formal training in these matters probably should not go much further than the material which the patient can tell him about consciously if given the opportunity. The uncovering of unconscious drives and motivations and the making of interpretations based on such factors are fields which the physician without special training had best stay out of.

In concluding, I would like to sum up these several thoughts in this manner: As one views what appears to be a cross section of medical practice, about half of it consists of medical problems which are wholly or in part emotional in origin. This huge segment of practice belongs to the entire field of medicine and must concern all physicians, not only psychiatrists. The general physician is the first line of defense in meeting these problems and therefore is the most important step in the entire stairway. There are definite principles and technics which can readily be learned with regard to both the diagnosis and the treatment of psychosomatic disease. Finally, let me again venture the prediction that this area of medical endeavor will become the specialty of the well trained general physician of the future.

Histamine in Certain Types of Headache*

By SAMUEL SALINGER, M. D.
Chicago

SAMUEL SALINGER

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HEADACHE is a symptom with which every physician has to deal, irrespective of his specialty. It is particularly of interest to ophthalmologists and otolaryngologists because of the proximity to the endocranium of the organs we treat. Patients come to us for the relief of headache because they feel that the symptom originates in one of these organs. Others are referred by medical men because general examination often fails to reveal the cause of the headache, and the physician suspects there may be a disorder within the field of eye, ear, nose, and throat. Frequently we do find such a lesion and can successfully treat it. At times, however, our local examination proves negative and we are forced to go back to general medicine for the answer. It is therefore incumbent on us to become familiar with the subject from both angles.

In general, it is safe to say that headache due to disease in any one of the special sense organs is manifested in the immediate locale of that organ. For example, headache due to eyestrain is experienced in the region of the orbit, though frequently radiating to other parts of the head, and is induced or aggravated by function. Headache or pain due to sinus disease is felt in the region of the affected sinus, is worse in the forenoon, and is aggravated by nasal obstruction. Similarly with headaches due to ear infection.

Neurogenic and Vascular Headaches

However, the headaches with which we are dealing in this paper are those which, though focusing in the region of the special sense organs, have nothing to do with them. These fall within two groups, namely, those which are due to involvement of sensory nerves or ganglia, and those which are due to vascular tension. In the first group we have the neuralgias and ganglion cell infections, and in the second group we have the sympathetic-parasympathetic affections due to mechanical, endocrine, or allergic factors.

It is naturally assumed that, before attempting an accurate appraisal of the case, a thorough examination has been made of the special sense organs to exclude local pathology. The findings must be correlated with the history because, even if some pathology is uncovered and the patient has periods of complete relief from headaches, while the local pathology is still present, it is unlikely that the two are related.

Differentiating the strictly neurogenic and ganglion cell headaches from those of vascular origin should in most cases be a simple matter if we but remember one basic fact, namely, that the former are experienced in the area of distribution of definite cranial nerves and ganglia, whereas the latter follow the distribution of the arteries. In the first group we have only to mention trigeminal neuralgia, glossopharyngeal neuralgia, and herpes zoster as typical examples. In each of these the manifestations are well defined, the attacks characteristic, and the course predictable. Trigger areas, tenderness, and eruption are so well known as to be unmistakable.

Vascular headaches, on the other hand, have come to be recognized only in recent years and are receiving more and more attention and study. It has been shown experimentally and clinically that distention of the endocranial blood vessels or traction or distortion will produce a headache which radiates along the distribution of the vessel. Our main interest now is bound up in a study of the factors that bring about these changes, and efforts toward remedying the causes. Aside from the expanding lesions of the brain and its appendages and inflammatory processes, we find that the causes of vascular headaches may be allergic, endocrine, hypertensive, and neuropsychogenic. Clinically, these factors manifest themselves in a variety of syndromes, some of which are clearcut and others less well defined. The most important are the following: histamine cephalalgia, migraine, tension and psychogenic headache, endocrine, physical allergy, and myalgia.

Special Syndromes

Briefly, the characteristics of these syndromes are as follows: Histamine cephalalgia occurs usually in middle life. The attacks come on during the night, are of short duration, but recur frequently. The pain is severe, focuses in and around the orbit, radiating throughout one side of the head, face and neck,

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

and is accompanied by nasal stuffiness, watery discharge, and lacrimation. This syndrome has been shown to be due to histamine and can be induced by a hypodermic injection of histamine.

Migraine

Migraine is a syndrome recognized for centuries. It usually comes on early in life. An inherited neurotic predisposition is frequently present, but the exciting factors are not always the same in all cases. The manifestations, however, are characteristic. Prodromal scotomata and lightning flashes are followed by severe hemicrania accompanied by nausea and vomiting, and often followed by paresthesias. These symptoms are all due to sudden changes in the vascular tension within the endocranium, caused by a disturbance of the autonomic nerve system.

Nervous Tension

Headaches due to nervous tension usually can be traced to some emotional upset, and persist only as long as the disturbing factor persists. Domestic difficulties, financial worries, and personal difficulties are usually at the bottom, and the patient obtains relief only when the disturbing element is eliminated. Change of scene frequently accomplishes wonders.

Psychogenic

Psychogenic headaches, on the other hand, are closely linked to deeper personality changes and are more diffuse and vague as to distribution and occurrence. In most cases the patient's appearance belies the severity of the pain of which he complains, and, as a rule, sleep is undisturbed.

Endocrine

Headaches of endocrine origin are most likely to appear in individuals who are naturally of nervous temperament, and seem to be most marked at the menstrual periods, in cases of premature menopause due to surgery or other causes, and in unmarried nulliparas. In these cases the headaches come in waves at irregular intervals, are usually diffuse, and can be precipitated by any number of influences, such as change in weather, irregular diet, and emotional upsets. These cases present a problem that taxes the utmost patience and ingenuity of the physician.

Physical Allergy

Physical allergy refers to the group of patients in whom headaches and other allergic phenomena develop following exposure to changes in temperature, extreme cold or heat, drafts, chilling, etc. In many of these the symptoms are referable to certain muscles about the head and are often termed myalgias. The pain is usually felt at the insertion of the muscle, such as the trapezius, sternomastoid, temporal digastric, etc., radiates along the bed of the muscle, and is often accompanied by local tenderness and swelling. Many observers are of the opinion that the condition is caused by the local release of histamine following exposure to the inciting agent.

In addition to the above-mentioned types we have post-traumatic, postoperative, and postherpetic headaches which exhibit similar characteristics.

In all the types outlined above, it is apparent that sudden changes in vascular tension due to irritation of the autonomic system constitute the fundamental pathogenic factor, and since in many cases they are similar to typical specific allergic reactions, it is generally believed that histamine plays a vital role. Histamine is a product of antigen-antibody reaction, and its action is fairly well understood. Histamine contracts smooth muscle, dilates the capillary bed, and stimulates natural secretions throughout the body. Since a specific allergen cannot in most cases be found, it is believed by many that desensitization can be accomplished through the administration of histamine in gradually ascending doses. This has been the treatment which Horton and many others, including myself, have found most effective. Naturally, one must not place complete reliance on this one agent when other etiologic factors are present. In many cases the administration of endocrine substances is called for on the basis of the history and physical findings. In other cases, the patient's personal habits need correcting. For example, we have observed instances in which the taking of even small amounts of alcohol would precipitate an attack. Exhaustive questioning of the patient as to the circumstances attending the onset of an attack will bring out these items, and, when the patient is warned to abstain and fails to do so, he will sooner or later have a recurrence which will make him more mindful of the connection. Likewise, emotional factors and mental stress must be overcome, and these often involve frequent interviews and lectures which will make the patient aware of the consequences which follow aberrations. The same applies to dietary indiscretions and excessive smoking.

Patients suffering from myalgias obtain the quickest relief from the local injection of novocaine into the painful area. Also, nicotinamide has proved effective when given over a period of time.

The allergic nature of most of these headaches is further attested to by the fact that relief frequently follows the administration of antihistamine agents such as benadryl and pyribenzamine.

Histamine Therapy

The methods of administering histamine therapy vary considerably. Horton favors the intravenous route. Injections are given daily or twice daily in ascending doses, highly diluted, at a very slow rate (15 to 40 drops a minute) for several weeks, and then followed by maintenance doses given hypodermically at longer intervals. Others are satisfied with the hypodermic method alone. Still others report good results from the use of hapamine, which

is histamine in combination with an azo-protein and which is claimed to stimulate the formation of specific antibodies. In any event, whichever course is followed, the essentials are the same, namely, starting with a minimal dose, administering frequently (daily or twice daily at first, later at longer intervals), increasing the dose gradually, and maintaining it at a level of tolerance as exhibited by flushing of the face, and headache. If the patient is completely relieved, the injections may be spaced at weekly or biweekly intervals and then discontinued if there are no recurrences. We have had patients take injections for a few weeks to a few months and be free from headaches for a year or more. In some cases the cure lasts indefinitely. Recurrences are usually due to the various inciting factors mentioned above. As a rule they respond to histamine therapy more rapidly than in the first instance, which would seem to support the contention that some degree of immunity has been obtained. This assumption, however, has not been proved.

Skin Test

A few words concerning the intradermal test for histamine sensitivity. I am not convinced that the test is entirely reliable, because much depends on the type of skin, room temperature, and dilution employed. Most individuals will exhibit some degree of local reaction in the shape of a wheal circumscribed by a hyperemic area. This cannot be interpreted as a negative reaction, because we have seen it in individuals who responded admirably to histamine therapy. The contrary, however, is not true. Patients who show a marked reaction such as a large wheal with pseudopods, a wide area of hyperemia, often with swelling and itching, are definitely histamine sensitive. In other words, we feel that the test is reliable only when definitely positive, but not to be depended on when negative.

Histories of Cases

We should like to cite a few typical cases in brief, illustrating some of the points outlined above.

Case 1.—*Histamine cephalalgia.*

L. B., a male aged 45, had recurring right hemicrania usually in the fall and winter, for a number of years. He had been treated off and on by several ear, nose, and throat men for chronic sinusitis and sphenopalatine neuralgia. Headaches appeared during the night in left frontal area and orbit, radiating into the neck, and were accompanied by lacrimation, stuffy nose, and watery discharge. Attacks often followed the taking of alcohol. There was a marked skin reaction to intrademal test. He was started on hapamine at 0.1 cc., increasing daily up to a full cubic centimeter. Relief was obtained after one week. The patient continued the weekly injections for several months, with no recurrence after lapse of one year.

Case 2.—*Cephalalgia and physical allergy.*

M. S., a female aged 35, had nasal obstruction on the left side, and the left ear felt blocked. There was a pounding sensation in the ear. Onset occurred a year previously. Frequent attacks were attended by flushed face and lacrimation. Hearing was normal. There was a marked reaction to a skin test. Injections of hapamine were begun, starting at .05 cc. Reaction occurred when the dose reached .2 cc. It was reduced to .1 cc. and then gradually increased to maximum of .8 cc. Relief was experienced after six injections. The patient has continued comfortable for months. There are slight recurrences when she takes cold, but they are usually of short duration.

Case 3.—*Cephalalgia; nervous tension.*

M. L. D., aged 30, had several headaches over the right eye and deep in the orbit. The neck felt stiff. Similar attacks had occurred over a period of years, starting with sharp pain in the forehead and sensation like a knife cutting through the eye. They usually lasted a week, with incomplete remissions. She got slightly dizzy and had tinnitus, also a bad taste in the mouth. There was a marked reaction to a skin test. She was started on hapamine. Reaction occurred at .2 cc. She obtained relief after ten days. Injections were continued for several months. She reported uneasy premonitory sensations, which, however, fail to materialize in the characteristic pain. The patient is very nervous and states that these sensations come on usually after periods of worry or mental stress.

Case 4.—*Myalgia.*

M. W. P., aged 38, had headaches starting in the upper back muscles radiating to occiput and ears. They were worse on the right side. These were experienced mostly during changes of weather or during the menstrual period. There was a sensation of fulness in the ears and a sensation of heat in the head. Tenderness was present in the left temporomandibular area. X-rays were negative. Pyribenzamine afforded some relief, but made her very drowsy. She received several injections of hapamine with marked relief. The patient left the city after a few months. She has not been heard from since.

Case 5.—*Endocrine.*

E. K., a female aged 26, was seen in April 1940. She had been dizzy off and on following a pregnancy. The dizziness was worse in the afternoon and evening. The basal metabolism rate was normal. Bubbling sounds were present in left ear. There was alternating nasal block and sneezing and occasional supraorbital pain. The eye, ear, nose, and throat examination was negative. Skin tests were negative.

In June 1942 she had vertigo for several weeks. She had had another baby eight weeks previously. Hapamine injection produced typical symptoms. Relief occurred after a number of injections.

In July 1945 she had had no symptoms for three years. Recently she has had nasal obstruction and headaches. Complete relief was obtained after a series of histamine injections.

Case 6.—*Migraine, neuralgia, myalgia, neurosis.*

M. K., a female aged 52, in 1944 had cough, gagging, and a choking sensation. Her brother had recently died of carcinoma of the esophagus. In 1946, she said she had had headaches for years. The right side of the nose was blocked and there were pains in the right eye and forehead with lacrimation. There was a marked reaction to a histamine skin test. Improvement was obtained under benadryl. Histamine injections were started. There was some nausea at first. The headaches disappeared entirely. Recently she had an attack of myalgia affecting muscles in back of neck. This was relieved after local injection of novocaine. Now she has severe pains in the infraorbital region and hard palate. There is tenderness over the posterior palatine canal orifice and infraorbital foramen. Teeth and sinuses

are negative. Allergy tests are negative. Some relief is obtained from local injections of novocaine. She refuses alcohol injection.

CASE 7.—*Cephalalgia.*

C.K.G., a male aged 26, had headaches over right eye, radiating to the back of the neck, usually during the night. The attacks were of short duration. There was no nausea but some lacrimation. Headaches disappeared after two weeks' treatment with hapamine. He has been keeping up the injections at weekly intervals and has had no recurrence in four months.

Summary

Headaches of vascular origin are due to disturbances of the autonomic nervous system. These may be allergic, endocrine, neuropsychogenic, physical, or of other complex origins. The symptoms are the result of the action of histamine. Successful therapy should include the elimination of the basic underlying factors. Relief may be obtained through the administration of histamine in ascending doses over a period of time.

Ringworm of the Scalp

Review of 100 Cases

By DONALD M. RUCH, M. D.

Milwaukee

D. M. RUCH

Doctor Ruch received his medical training at the University of Rochester School of Medicine, graduating in 1941. He received his master of science degree in dermatology in 1945 from the Graduate School of the University of Minnesota. A diplomate of the American Board of Dermatology and Syphilology, the doctor is now engaged in private practice in Milwaukee.

THE incidence of tinea capitis, or ringworm of the scalp, has been on the increase in the United States in the past five years, particularly the last two years. It became epidemic in New York City, Boston, and Philadelphia in 1943 and 1944, in Chicago a year later, and it has reached epidemic proportions in Milwaukee the past year. Exactly 500 cases were reported to the Milwaukee Health Department from April 1, 1946 to April 1, 1947, whereas only a few cases were reported prior to 1946. As this is not a reportable disease, the actual number of cases must be considerably larger. For this reason I feel that it is worth while to review the pertinent findings in 100 cases of tinea capitis seen at the Milwaukee Children's Hospital outpatient department in the past year (April 1946 to April 1947).

Tinea capitis is a superficial infection of the scalp caused by several different fungi and occurs chiefly in children before the age of puberty. For all practical purposes, over 90 per cent of all cases in the present general epidemic are caused by either *Microsporum audouini* or *Microsporum lanosum.* It is extremely rare for either of these organisms to cause tinea capitis after the age of puberty. *Trichophyton gypseum* is also a cause of tinea capitis in both children and adults, especially in the rural areas, and in addition both *Microsporum lanosum* and *Trichophyton gypseum* can be the cause of lesions on the non-hairy skin of the adult. It has been stated recently by Rothman that the spontaneous cure of *Microsporum audouini* infections of the scalp at puberty is related to sterilization of the hair follicles by fungicidal free fatty acid fractions of the scalp sebum which appear during puberty.

The types of tinea capitis resulting from infection by these fungi vary in their epidemiology, clinical and cultural characteristics, course, degree of contagiousness, and response to treatment. These differences are so important that identification of the causative organism is essential in the management of each case. Favus of the scalp, caused by *Achorion schoenleini,* is extremely rare in this country and need not be considered here.

Clinical Types

1. *Gray Scaly Patch type.—Microsporum audouini* causes the so-called gray, scaly, patch type of ringworm of the scalp. Single or multiple areas of partial alopecia with lusterless, short, stubby hairs are present on the scalp. A fine gray scale is usually present in the affected areas, and there is very little or no inflammation to be seen. This type of ringworm is of human origin and is highly infectious and contagious but does not infect animals. It is transmitted by direct contact or by contact with combs, clippers, caps, chairs, pillows, head rests, and the like. The infection is insidious and may persist for many months or years. Occasionally *Microsporum lanosum* also causes this superficial type of infection.

2. *Kerion Type.—Microsporum lanosum* and *Trichophyton gypseum* cause the kerion type of tinea capitis, with *Trichophyton gypseum* as the most common cause of kerion in rural areas and on the

adult scalp. This is an active, often highly inflammatory type of infection with lesions varying from well circumscribed single or multiple areas of redness, crusting and pustulation to areas of abscess formation and carbuncle-like granulomas. Infected cats, dogs, and cattle can be the source and focus for spreading the infection among children. It is also transmissible from child to child. The duration is usually several weeks or months, and in this type there is a tendency to spontaneous cure. Occasionally the *Trichophyton violaceum* fungus is found as the cause of the kerion type of infection of the scalp.

Diagnosis

For the diagnosis of tinea capitis, a Wood lamp is desirable. This lamp invented by Robert Wood, an American physicist, provides ultraviolet rays which are passed through a special filter composed mainly of nickel oxide. When a source of ultraviolet light is screened with this filter glass, all visible rays are absorbed while the ultraviolet rays are transmitted through the filter. Certain substances such as infected hairs from a patient with tinea capitis fluoresce in a characteristic manner when exposed to the filtered rays in a darkened room. The Westinghouse Purple X lamp is a suitable inexpensive substitute for the ordinary glass Wood filter. It will fit into any standard light socket and must be flashed intermittently because its construction will not permit it to burn steadily for more than a few seconds at a time.

The patient is first examined in a well lighted room to determine the clinical characteristics of the scalp infection. A provisional diagnosis is made, and, one determines whether or not it is the gray, scaly, patch type or the kerion type of ringworm. The room is then darkened and the patient is examined with the Wood light or the Purple X lamp. The lamp is held close to the patient's scalp and the examiner runs an applicator carefully through the patient's hair so as to separate the hairs and expose the scalp. The infected hairs glow or fluoresce as bright, clear, silvery-green stubs. The provisional diagnosis of tinea capitis is confirmed if such fluorescence is present, although it must be kept in mind that hair infected by *Trichophyton gypseum* does not fluoresce.

In differential diagnosis the examiner must consider such entities as alopecia areata, seborrheic eczema, psoriasis, pyoderma, and folliculitis. The kind of fluorescence due to ointments which may have been applied is different in that it gives a blue-white color and is ill defined and smeared rather than sharply demarcated; also the greasy hairs fluoresce throughout their entire length rather than as stubs.

Next the fluorescent hair is placed on a glass slide and several drops of 10 per cent potassium hydroxide solution are added and a cover slip is overlaid. This preparation should be heated gently for a few seconds, but not boiled, and then examined under the low power objective of the microscope with the condensor diaphragm closed as far as possible. The infected hairs have a ground glass appearance with spores present on the outside or within the shaft. The normal uninfected hairs have a clear, clean, waxy, translucent appearance.

The next laboratory procedure is culture of the infected hairs. This is the only practical method of accurately identifying the causative organism and is important in determining the type of therapy. Several fluorescent hairs are plucked from the scalp and planted onto the surface of Sabouraud's agar medium. The culture is kept at room temperature and examined in seven to ten days. In two to three weeks *Microsporum audouini* forms closely matted, velvety aerial mycelia, light gray to brown in the center with radiating furrows. The reverse side or undersurface of the colony is reddish-brown to orange in color. The growth of *Microsporum lanosum* is thick, fluffy and abundant, powdery in texture, buff to light brown in color. The reverse side or undersurface is bright lemon yellow. *Trichophyton gypseum* cultures are powdery to granular, light buff to rose tan in color and may vary from a fluffy cotton type to a velvety type of growth. The reverse side of the colony is wine colored to brown.

Further identification may be carried out by examination of small portions of the culture microscopically by the same technic used for the examination of the infected hairs. One, however, needs some special knowledge of mycology to identify the types and characteristic spores of the various fungi.

Clinical Review

Incidence.—One hundred cases of tinea capitis were seen in the outpatient department of the Milwaukee Children's Hospital from April 18, 1946 to April 21, 1947. Only 1 case was seen in the five year period prior to 1946. These hundred cases constituted 87 per cent of all patients with fungus infection seen at the clinic during that period of one year. They also represented 63.5 per cent of all cases seen in the Dermatology Clinic during the months of March and April 1947. The incidence according to sex shows that more than four times as many boys were infected as girls, as is shown below:

Males	81
Females	19
Total	100

The age group with the highest incidence was that from 7 to 10 years of age, 67 per cent of the patients falling within this age limit. Fifteen patients were 7 and 9 years of age respectively, 12 were 8 years of age, and 19, the highest number for a given age, were 10 years old. As to the family incidence, it is interesting to note that in seventeen families there were 2 members with tinea capitis and in one family 3 children were infected.

The following list shows the incidence according to the clinical types of tinea capitis:

Gray scaly patch	97
Kerion	3
Total	100

The regions of the scalp that were involved varied considerably in frequency, the occiput being involved more often than any other part of the scalp. There were 49 cases with occipital involvement, 10 with parietal involvement, 9 crown, 6 temporal, 6 frontal, 1 mastoid, and 19 showed scattered areas over most of the scalp. Forty-seven had only a single infected area on the scalp, 18 had two areas, 16 had three areas, and 19 had four or more areas. In 4 of the 100 cases there were lesions of ringworms on the body (tinea corporis), and 1 patient showed the typical allergic or "id" reaction on the body to the fungus infection on the scalp.

Treatment

Types and Results.—Three main types of treatment were employed in the management of these cases: x-ray epilation, manual epilation, and topical therapy. We were able to follow adequately 91 of the 100 cases. and the data concerning treatment are based on these.

Three patients with the kerion (*Microsporum lanosum*) type of infection were treated locally with potassium permanganate wet dressings (1–10,000) applied two or three times a day, and fungicides. Sulphur, salicylic acid, ammoniated mercury, iodine, and other fungicides were also used locally several times a day after the wet dressings. All 3 patients were cured in from three weeks to two months. In this type of infection x-ray epilation is not necessary because the inflammation is often so intense that spontaneous epilation occurs.

The 88 patients with the gray scaly patch (*Microsporum audouini*), in which there was an adequate follow-up, were treated as follows: x-ray epilation was used in 61 of the cases, manual epilation in 8 patients, and local therapy alone for 19 patients. Of the 61 epilated by x-ray, 40 were first subjected to local therapy consisting of fungicidal wet dressings and ointments such as were applied in the cases with the kerion type of infection. These measures were ineffective in the gray scaly patch type of infection, and for this reason the remaining 21 patients were epilated by x-ray and received no preceding topical therapy.

Patients with this type of infection who had single or only a few small areas from 1 to 2 cm. in diameter were epilated manually by the nurses at the clinic. This was done in 8 cases and proved effective in 4. A special epilating tweezers was used, and it was done under the Wood light.

Epilation of the scalp with x-rays should be carried out only by those thoroughly trained and experienced in this procedure. Thousands of patients have been epilated in large clinics in New York City and other centers without accident, but if errors are made, permanent loss of hair and scalp atrophy may result. It is not within the scope of this paper to go into detail concerning the procedure for epilation by x-ray. The hair usually falls out in about three weeks and then begins to regrow in three more weeks. It is important to state that the entire scalp should be epilated and not individual areas even though only one or two sites are involved. The x-rays have no direct fungicidal effect but by their action on the cells of the hair follicle cause the hair to fall out carrying the fungus with it. After epilation is completed a fungicidal topical application as described before should be used for several weeks to prevent reinfection.

Prevention plays an important role in the management of these cases. The children were permitted to attend school and movies and play with other children provided stocking caps were worn day and night. Most wore thin cotton caps, and a clean paper napkin was placed on the inside of the cap each day to prevent the infection from spreading to other areas of the scalp.

The results of treatment in the 91 cases of tinea capitis are listed below:

	Number of Cases	Percent
Cured	67	74
Improved	9	10
Failed	15	16

We concluded from our experience that x-ray epilation or manual epilation is the most effective treatment for the gray scaly patch type of tinea capitis. When facilities for x-ray epilation are not available, then manual epilation and fungicides are to be used. The kerion type of infection responds well to local applications of fungicides, and one should keep in mind that x-ray epilation is not necessary in this type.

Summary

Tinea capitis has assumed a position of considerable importance in the past two years for it has reached epidemic proportions in many cities and towns in the midwestern and eastern United States.

The clinical characteristics of the two main types of ringworm, namely, the gray scaly patch type and the kerion type are described.

Certain procedures are essential for the accurate diagnosis of tinea capitis. They include the use of the Wood light or Purple X lamp, microscopic examination, and culture of the infected hairs.

One hundred cases of tinea capitis are reviewed with reference to the incidence as to age, sex, type of infection, family incidence, and frequency of involvement of the various regions of the scalp.

As to treatment it was concluded that all patients with the gray scaly patch type should, if possible, be treated by x-ray epilation or manual epilation. The kerion type of infection should be treated by topical fungicides. An important part of the management is prevention.*

*Since this article was written an additional 101 cases were seen from April 21, 1947 to February 15, 1948. The observations as recorded above apply equally to the later group.

Research Project on Appendicitis in Rock County*

By THOMAS J. SNODGRASS, M. D., *Janesville* WAYNE A. MUNN, M. D. *Janesville*

and

THOMAS FLARITY, M. D.
Beloit

NO THERAPEUTIC measure has any great value unless it is available to the mass of people. Many operations of great magnitude are performed by specialists in a limited field, and their accomplishments are evidence of the progress being made in surgery. However, many of these operations are of somewhat doubtful value, are performed on a limited number of patients, and have little effect on the general health of the population. A somewhat analagous condition exists in the matter of clinical research. The literature abounds with statistical reports of various operations performed by highly skilled surgeons or residents under close supervision in the large medical centers, but seldom is any attempt made to evaluate the work of the average surgeon or general practitioner in the smaller hospitals throughout this country, where the majority of the population is treated.

In Wisconsin we have two medical centers in which valuable research is being carried on. There are approximately 750 to 800 beds under direct control of the University of Wisconsin Medical School. Another large group in our only metropolitan center is available for teaching but is not under direct control of the medical faculty. On the other hand, there are 8,000 beds in general hospitals in the state approved by the American College of Surgeons, not to mention the smaller hospitals and others that are not on the approved list. In all of these institutions there is a large amount of surgical treatment being carried out, and it is evident that the statistics from one or two large institutions in the state, representing less than 10 per cent of the total hospital beds, cannot give a true picture of the results of surgical treatment in this state. It is our feeling that surveys such as have been carried out on a county-wide basis by the Rock County Medical Society more truly represent the results of surgical treatment in this country.

The completion of the five year period (1942-1946) covered in the present report rounds out a forty year study of 8,242 cases of appendicitis in which patients were operated on in Rock County. One of the striking results noted in this second period of the survey is the improvement in records and detailed information available. A little increased activity on the part of the record committee and a competent record clerk in the hospital will make it possible to keep these statistics up to date, so that they can be reviewed every year as a part of the staff program. This information should be stimulating as well as a measure of the competence of the surgical staff.

In 1939 one of us (T.J.S.) reported a series of 16 cases of ruptured and gangrenous appendices treated with sulfanilamide and surgery with no deaths. During the same period there were 18 similar cases in which the patients were treated without sulfanilamide, with 9 deaths. This was early in the use of sulfanilamide (May 1938), and it was given entirely by mouth and often in inadequate doses. Though the series was small, it pointed to the possibility that in this drug we had some means of controlling the complications following ruptured and gangrenous appendicitis.

In 1943 (Snodgrass, T. J., Munn, W. A., and Flarity, T.: Thirty-Five Year Survey of Appendicitis in Rock County, Wisconsin M. J. 42: 928–932 [Sept.] 1943) we presented to this Society a survey of 6,482 cases of appendicitis in which patients were operated on in Rock County. Part of these cases extended over a thirty-five year period, and 4,327 were collected from 1929 to 1942. In the acute cases of this group only 1.5 per cent were fatal; but in the cases of gangrenous, ruptured, and abscessed appendices the mortality rate was 12 to 14 per cent.

During the last four years of the survey (1938-1942) sulfanilamide and similar drugs were used in appendicitis in addition to surgery. There were 109 such cases, with 9 deaths, or a mortality rate of 8.2 per cent. Again it was evident that many times the drug had been used late and in small quantities, but there still was a definite drop in the mortality in the complicated cases. In one of the hospitals the use of sulfanilamide was not started until the intraperitoneal method was introduced. Following the utilization of this treatment there was a series of 39 cases of ruptured and gangrenous appendices with 1 death. In this study it appears that for thirty-five years little or no progress was made in the treatment of appendicitis in spite of the great progress made in surgery during that time. Not until the introduction of sulfanilamide was there a definite drop in the mortality rate.

The importance of early diagnosis and early surgery was brought out in this study, and the inadequacy of histories and records as prepared by the attending physician was apparent. It also appeared that surgical treatment of appendicitis by a large

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

group of doctors not specially trained in surgery definitely increased the mortality rate.

It was with special interest that this "Research Project on Appendicitis in Rock County" was resumed for the period of 1942 through 1946, during which time progress was made in chemotherapy of disease. The use of sulfonamides in appendicitis was well established, and some of the larger hospitals had reported large series of suppurative and gangrenous appendicitis without a single death. Penicillin was also made available during this time and its administration and dosage fairly well standardized. It was the hope of the committee that with all these newer aids there would be a definite decrease in mortality and morbidity. In the discussion to follow we will cover principally the more serious types of appendicitis, with somewhat detailed discussion of the cases which resulted fatally.

TABLE 1

Years	Cases
1942–1946 inclusive	1, 760

TABLE 2

Male	Female	Total
713	1, 047	1, 760

Age Incidence

Age	Total Cases
9 years and under	179
10–19 years	731
20–29 years	426
30–39 years	204
40–49 years	92
50–59 years	42
60 and over	54
Not recorded	32
	1, 760

Tables 1 and 2 show the number of cases studied and the distribution. As noted, by far the largest number of cases occur in the second decade of life, and the number decreases in frequency in succeeding decades.

TABLE 3.—*Seasonal Incidence*

Month	Total Cases
January	154
February	159
March	149
April	159
May	154
June	137
July	141
August	174
September	142
October	137
November	116
December	138

Table 3 shows the seasonal incidence, which is without significance.

TABLE 4.—*Mortality Rate*

Total:	Years	Cases	Deaths	Per cent
	1907–1942	6, 482	174	2.7
	1942–1946	1, 760	18	1.0
Group I:	1907–1929	2, 151	36	1.7
	1929–1942	2, 025	58	2.9
	1942–1946	899	14	1.6
Group II:	1929–1942	2, 062	70	3.4
	1942–1946	861	4	.5

In table 4 the mortality rate (1907–1942—6,482 cases) was 2.7 per cent. In 1,760 cases (1942–1946) after the introduction of sulfanilamide and penicillin, the mortality rate dropped to 1 per cent. Significant differences in the statistics in two groups of hospitals in the different communities are shown separately. Group I, in which the statistics were available back to 1907, showed 2,151 cases between 1907 and 1929 with 36 deaths—1.7 per cent mortality; 1929–1942, 2,025 cases with 58 deaths—2.9 per cent mortality; 1942–1946, 899 cases with 14 deaths —1.6 per cent mortality. Group II, with statistics available from 1929 to 1942, had 2,062 cases with 70 deaths, with a mortality rate of 3.4 per cent, originally considerably higher than in group I; but from 1942 to 1946, in 861 cases there have been only 4 deaths, a mortality rate of .5 per cent, which is a remarkable accomplishment.

TABLE 5

Type	Cases	Mortality	Per cent
Acute	502	2	.39
Acute gangrenous	278	3	1.07
Acute with perforation	128	10	7.7
Subacute and chronic	892	3	.33
Group I:			
Acute with perforation	40	9	22.5
Group II:			
Acute with perforation	48	2	4.1
Acute with pin worms	25		
Chronic with pin worms	44		

Table 5 shows that the mortality rate in acute cases was less than .4 per cent; in acute gangrenous cases 1 plus per cent; and in 128 acute cases with perforation there were 10 deaths, a mortality of 7.7 per cent. This type of appendicitis is still the most dangerous and the most difficult to control. In 892 subacute and chronic cases there were 3 deaths, a mortality rate of .3 per cent. Again there was a great difference between groups I and II. In group I there were 40 acute cases with perforation, with 9 deaths—22 per cent mortality; and in group II there were 48 acute cases with perforation, with only 2 deaths—4.1 per cent mortality rate. A third smaller hospital in the county reports 180 cases—135 acute and 45 chronic—for the period from 1943 to 1946 with no deaths.* It is noted with some interest that there were 69 cases in which pin worms infested the appendix.

TABLE 6.—*Age and Mortality Incidence*

Age	Total Cases	Deaths	Mortality, %
9 years and under	179	3	1.6
10–19 years	731	5	.68
20–29 years	426	1	.23
30–39 years	204	1	.49
40–49 years	92	2	2.1
50–59 years	42	0	----
60 and over	54	6	11.1
Not recorded	32	0	----

Table 6 shows the age and mortality incidence. Under 9 years of age there were 179 cases with 3 deaths—1.6 per cent mortality. Between 10 and 19 years there were 731 cases, with 5 deaths—.68 per cent mortality. In the 40 to 49 year group there

* Not included in statistics.

TABLE 7.—*Cause of Death as Determined from the Records*

Cause	Type of Case		Deaths	Per cent	Total Cases
Peritonitis	Acute	1	10	.56	1,760
	Acute with perforation	6			
	Gangrenous	3			
Pulmonary embolism	Chronic	1	2	.11	
	Acute with perforation	1			
Coronary occlusion	Ruptured and abscessed	1	1	.05	
Anesthetic death	Acute with perforation	1	1	.05	
Cerebral edema (toxic)	Acute with perforation	1	1	.05	
Cerebral hemorrhage	Acute	1	1	.05	
Cerebral embolism	Chronic	1	1	.05	
Pulmonary atelectasis	Subacute	1	1	.05	

were 92 cases with 2 deaths—a little over 2 per cent mortality; and in the 60 year and over group there were 54 with 6 deaths—11 per cent mortality. It still appears that the mortality in appendicitis is greater in the very young and in the old age group.

Table 7 shows the cause of death as determined from the records. Peritonitis leads them all with 10 deaths—1 in the acute, 6 in the acute with perforations and 3 in the gangrenous. Pulmonary embolism is next in line with 2 deaths—1 in chronic and 1 in acute with perforations. Coronary occlusion, anesthetic death, cerebral edema, cerebral hemorrhage, cerebral embolism, and pulmonary atelectasis have 1 each.

TABLE 8.—*Average Number of Hospital Days, Type of Anesthesic Used, and Chest Complications*

Average hospital stay—8½ days

Anesthetic	Cases	Chest Complications	Cases
Ether	410	Pneumonia	2
		Pulmonary Embolus (nonfatal)	1
Ethylene	607	Pneumonia	7
Ethylene and ether	185	Pulmonary embolism (nonfatal)	2
Cyclopropane	230	Lobar pneumonia	2
		Pulmonary embolus	1
Cyclopropane and curare		Respiratory paralysis	1
Nitrous oxide	140	Atelectasis	1
Spinal	154	Pulmonary embolus	1
Ethyl chloride and ether	11		
Sodium pentothal	2		
Local anesthesia	4		
Not recorded	17		

Table 8 shows the average hospital stay to be eight and one-half days, while in the previous survey the average hospital stay was eleven days. With early ambulation and more effective use of our present methods, doubtless the hospital stay will be considerably reduced in the next five-year period. Table 8 also shows the different types of anesthetics being used, with the complications. Inhalation anesthesia is still the most popular, with open drop ether being used in 410 cases. This survey does not show to what extent curare was used in conjunction with other anesthetics, but for a time it was quite popular as an adjunct in inhalation anesthesia.

TABLE 9.—*Duration of Symptoms With Mortality Rate*

Time	Total Cases	Deaths	Per cent
1–24 hours	526	1	.19
1– 2 days	268	6	2.21
2– 3 days	194	4	2.06
3– 4 days	134	3	2.2
4–21 days	217	1	.46
Over 21 days	338	2	.61
Not recorded	83	1	1.2
		18	

Table 9 shows the relationship of the duration of symptoms to the mortality rate. In 526 patients that were operated on within twenty-four hours there was only 1 death; in 268 patients operated on in the forty-eight hour period, 6 deaths—a mortality rate of 2.21 per cent; in 194 patients operated on in a two to three day period, 4 deaths—2.06 per cent mortality; in 134 patients operated on in the three to four day period, 3 deaths—slightly over 2 per cent mortality; in 338 patients operated on after twenty-one days there were only 2 deaths—about .6 per cent mortality. In the former survey the period of delay seemed to be extremely important as the cause of death. In the one to twenty-four hour cases the death rate was 2 per cent; in the forty-eight hour group it jumped to 4 per cent; in the three day group to 12 per cent; in the four day group to 11 per cent. The delay that places the case in the danger zone is still a factor to be considered. The preoperative use of large doses of penicillin and sulfonamides along with other supportive treatment may be more effective than immediate operation in controlling disease.

TABLE 10.—*Symptoms in Acute Cases*

Pain	Tenderness	Nausea	Rigidity	Vomiting	Previous Attacks	Laxative
+ 1,737	+ 1,572	+ 1,239	+ 819	+ 651	None 501	+ 54**
— 4	— 47	— 182	— 278	— 266	Less than 3 458	— 1,661
*N.R. 19	N.R. 141	N.R. 339	N.R. 663	N.R. 843	Several 478	N.R. 45
					N.R. 323	

Group II

Nausea with vomiting	442
Nausea without vomiting	238
No nausea or vomiting	76
Not recorded	105
	861

*N.R. = Not recorded.
**Gangrenous, unruptured 20; unruptured 28; ruptured 2; chronic 4.

Table 10 is an attempt to analyze the symptoms in acute cases. Pain, tenderness, nausea, vomiting, and rigidity are the most common symptoms. Very few in this series received laxatives at home previous to the operation. Of the 52 that received laxatives, 20 were gangrenous and not ruptured; only 2 were ruptured. An analysis of the 861 cases of group II showed 442 with nausea and vomiting; 238 showed nausea without vomiting; 76 showed no nausea and no vomiting.

TABLE 11.—*Preoperative Complications*

Complications	Cases
Upper respiratory infection	124
Pregnancy	19
Peritonitis	6
Acute enteritis	6
Nephritis	6
Gastric ulcer	7
Measles	3
Spastic bowel	3
Tonsillitis	2
Salpingitis	3
Hematemesis	2
Nocturia	2
Asthma	5
Secondary anemia	1
Jaundice	1
Pyelitis	1
Mitral heart disease	3
Albuminuria	2
Myocarditis	2
Diabetes	1
Cholecystitis	1
Infection from self-induced abortion	1
Chronic cystic mastitis	1
Hay fever	1
Mumps	1
Malaria	1
Lues (latent)	1

Table 11, preoperative complications, shows upper respiratory infections and pregnancy the most common—124 of the former and 19 of the latter.

TABLE 12.—*Postoperative Complications*

Complications	Cases
Upper respiratory infection	82
Peritonitis	75
Urticaria	13
Postoperative hemorrhage (wound)	10
Pneumonia	11
Abscess	15
Nephritis	9
Cystitis	8
Thrombophlebitis	8
Evisceration of wound	7
Singultus (?) (hiccough)	7
Stitch abscess	5
Epistaxis	4
Hemoptysis	4
Jaundice	3
Pulmonary embolus	4
Dermatitis	2
Adenitis	2
Calculus (renal)	1
Enteritis, acute	1
Parotitis	2
Conjunctivitis	1
Herpes zoster	1
Fecal fistula	1
Pulmonary atelectasis	1
Cerebral hemorrhage	1
Cerebral embolus	1
Cerebral edema (toxic)	1

The postoperative complications in table 12 show 82 upper respiratory infections; 75 peritonitis; 13 urticaria, a new complication resulting from the use of various types of drugs; 10 postoperative wound hemorrhage; 11 pneumonia; and 15 abscesses.

TABLE 13

Number of Operators	66
Group I	33
Group II	33
Type of Incision	
Right rectus	903
McBurney	544
Transverse	79
Oblique	27
Midline	85
Not recorded	122
Group I—Right rectus—610	Group I—McBurney—137
II—Right rectus—293	II—McBurney—407

Table 13 shows 66 men operating, 33 in each group. In the previous survey, group I had 25 physicians performing 4,176 appendectomies, while group II had 38 physicians doing 2,062 operations. Group I had a general mortality rate of 2.3 per cent against 3.4 per cent in group II. In ruptured and gangrenous cases the mortality in group I was 11 to 12 per cent and in group II 12 to 18 per cent. In the present survey group I has 8 more surgeons performing 899 operations, and group II has 5 less surgeons performing 861 operations. In approximately the same number of operations the mortality rate in group I is 1.6 per cent and in group II is .5 per cent. In acute cases with perforation the mortality rate of group I is 22½ per cent against 4.1 per cent in group II.

In the matter of incisions, the right rectus is still the most popular, with 903 against McBurney 544; the transverse and oblique are also probably muscle-splitting incisions. In group I, in which the mortality rate is the higher, the right rectus was used most frequently, with 610 against 137 McBurney; while in group II, with the lower mortality rate, McBurney was used 407 times against the right rectus 293 times.

Table 14 shows the leukocyte count and its relationship to the temperature. One thousand ninety-seven patients had a leukocyte count of 10,000 or over, and 855 of these had a temperature of 99 F. or over. The lower part of this table lists 10 cases of perforated appendicitis with a leukocyte count of less than 10,000, and none of these were fatal.

Table 15 outlines the sulfa and penicillin therapy. The term sulfa alone indicates that it was given orally or parenterally; abdominal means it was placed in the abdominal cavity. In group I there were 247 who had sulfa alone or sulfa introduced into the abdomen with 5 deaths; in group II there were 152 with no deaths. Penicillin was used 16 times in group I with no deaths, and 20 times in group II with 2 deaths. In the combined use of sulfa and penicillin, group I had 27 cases, with 3 deaths; group II had 40, with 2 deaths. In sulfa therapy the average intraperitoneal dose in both groups was 75 gr. (5 Gm.), the smallest total amount was 15 gr. (1 Gm.), and largest total amount 1,515 gr. (101 Gm.). In penicillin therapy the smallest total amount used in group I was 25,000 units and the largest total amount 2,040,000 units; while in group II, in which the mortality rate was

TABLE 14.—*Leukocyte Count and Temperature*

White Blood Cell Count	Cases
4, 000 to 7, 000	271
8, 000 to 9, 000	329
10, 000 to 15, 000	535
15, 000 and above	562
Not recorded	63

Temperature on Admission

310 patients had normal temperatures on admission
200 patients had temperature of 99 F.
585 patients had temperature below 99 F. } 1, 443
655 patients had temperature above 99 F.
10 patients had temperature not recorded

Pulse on Admission

1, 298 patients had pulse below 100
455 patients had pulse above 100
7 patients had pulse not recorded

627 patients out of 1, 097 that had leukocyte count of 10,000 or over had had temperature of 99 F. or over

History in 10 Cases of Gangrenous Perforated Appendix With Leukocyte Counts of Less Than 10,000

White Blood Cells	Stabs	Segmented Cells	Lympho-cytes	Monon-cytes	Temperature	Diagnosis
9, 450					100	Ruptured appendix with abscess
6, 500					100	Acute suppurative appendicitis
9, 550					99	Acute suppurative appendicitis
8, 400					97.6	Acute suppurative appendicitis
7, 650					101.	Acute, diffuse, purulent
7, 600					101.	Acute, diffuse, gangrenous, perforated
9, 800					98.6	Acute with peritonitis
7, 600					101.	Acute, gangrenous with perforation
9, 300	8	79	12	1	99.4	Acute, purulent appendicitis with abscess
5, 800	16	62	19	3	103.6	Acute appendicitis with perforation

None of these cases were fatal

TABLE 15.—*Sulfa and Penicillin Therapy*

	No. Cases	Deaths
Sulfa alone or abdominal		
Group I	247	5
Group II	152	0
Penicillin alone		
Group I	16	0
Group II	20	2
Sulfa and penicillin combined		
Group I	27	3
Group II	40	2

Sulfa Therapy

	Average Abdominal Dosage	Smallest Total Amount	Largest Total Amount
Group I	75 gr. (5 Gm.)	15 gr. (1 Gm.)	1, 515 gr. (101 Gm.)
Group II	75 gr. (5 Gm.)	15 gr. (1 Gm.)	1, 147 gr. (76.4 Gm.)

Penicillin Therapy

Group I	25, 000 units	2, 040, 000 units
Group II	40, 000 units	16, 620, 000 units

Drainage

	With Drainage	Without Drainage
Group I	55	235
Group II	85	127
	140	362

reduced to .5 per cent, 40,000 units was the smallest total dose and 16,620,000 units the largest total dose. This is significant because it has become quite evident that enormous doses of penicillin have to be used early in order to control peritonitis.

Despite the remarkably low mortality, it is well to analyze the individual cases that resulted fatally and determine if there is any possibility that some modification in treatment might have brought about a more favorable result. Group II, with 861 cases, 4 deaths, and a mortality rate of .5 per cent will be considered first.

CASE 1.—The patient was a male, age 60, with acute, purulent, perforated appendicitis of forty-eight hours' duration. He was operated on immediately under ethylene anesthesia. The stump of the appendix was inverted, 75 gr. (5 Gm.) of sulfanilamide placed in the peritoneal cavity, and the abdomen drained. He was given 760,000 units of penicillin, blood transfusions, and plasma. On the second day distention developed. Wangensteen drainage was started on the third day. He was given tea, hot water, orange juice, root beer, and other fluids by mouth. He was given an enema on the fifth and seventh days and on the eighth day cascara, mineral oil, prostigmin and turpentine stupes. On the fourteenth day he was re-explored for abscess, but none was found. The program of nasal suction, feeding by mouth, and enemas was continued. He died on the twenty-first day, apparently a cardiac death. This was peritonitis in the older age group. Cause of death was given as coronary embolism.

CASE 2.—The patient was a female, age 77, with pain and diarrhea of forty-eight hours' duration, at first considered gastroenteritis. The abdomen

was distended before surgery. Preoperatively the patient was given a soapsuds enema. She was operated on at the end of forty-eight hours. A right rectus incision was used, 75 gr. (5 Gm.) of sulfanilamide placed in peritoneal cavity, and the abdomen drained. This was acute, purulent, gangrenous appendicitis. Both of these cases showed Bacillus coli and Streptococcus in the culture. Postoperatively the patient had a high fever. A soapsuds enema followed the operation, and Wangensteen drainage was started. The third day the enema was repeated, because of the distention of the abdomen. Pituitrin was given on the fifth day and pitressin on the sixth. The patient died of general peritonitis on the seventh day. Patient had the advantage of intravenous medication, but was also given ice chips and water by mouth. Cause of death was general peritonitis.

Case 3.—The patient was a male, age 42, sick forty-eight hours. Ethylene anesthesia was used along with a muscle-splitting incision. Sulfathiazole of an unknown amount was placed in the abdominal cavity. This was a case of acute, purulent, gangrenous appendicitis. Fifty thousand units of penicillin were administered every four hours, and tea, water, broth, and white soda were given by mouth. The second day, because of distention, he was given prostigmin and a Mayo enema. Prostigmin was repeated the second postoperative day and Wangen steen drainage started. A Mayo enema was given on the third day. The seventh day a fecal fistula developed. Enemas were continued and plasma given on the tenth day. On the eleventh day a soft diet of milk, ice cream, and fruit juice was given. On the eleventh day some postoperative bleeding developed, and the patient was treated with plasma and vitamin K. Peritonitis and wound hemorrhage were considered the cause of his death.

Case 4.—The patient was a female child, 14 years of age, sick forty-eight hours. Immediate operation was performed through a McBurney incision, and 75 gr. (5 Gm.) of sulfanilamide placed in the abdomen. Appendix was perforated, with free pus in the peritoneal cavity. The child expired on the fourth postoperative day despite the use of 850,000 units of penicillin and 45 gr. (3 Gm.) of sulfa orally. Transfusions of glucose in saline were used in addition to soft diet the first day. Distention and vomiting developed, and a Mayo enema and prostigmin were given the second day. The third day a soapsuds enema was given and Wangensteen drainage was instituted. General peritonitis was the cause of death.

Turning to group I, there were 14 deaths in 899 cases, 6 of which occurred in less than forty hours.

Case 1.—The patient was a female, age 5, sick twenty-four hours; the appendix was perforated. Cyclopropane anesthesia was used, and, because of some difficulty in overcoming laryngeal spasm and proper relaxation, a small dose of curare was given and resulted in immediate respiratory paralysis, from which patient did not recover.

Case 2.—The patient was a child, age 11, sick thirty-six hours, with acute appendicitis. During the ether anesthetic, the patient vomited large amount of material and aspirated it, producing a massive atelectatis, which was confirmed at the autopsy. The patient died the first day.

Case 3.—The patient was a child, age 4, sick forty-eight hours, with acute appendicitis with necrosis and operated on under ether anesthesia. Enema was given preoperatively. The child had high fever and high leukocyte count and died of peritonitis the first postoperative day.

Case 4.—The patient was a male, age 47, classed as having chronic appendicitis and operated on under an ether anesthetic. The next morning he showed some shortness of breath and died within an hour. This was diagnosed as pulmonary embolism.

Case 5.—The patient was a male, age 17, sick twelve hours with a perforated appendix and operated on under nitrous oxide anesthetic. The patient returned from surgery with a pulse rate of 160, was irrational, did not recover from the anesthesia, and died on the second day.

Case 6.—The patient was a female, age 9, sick forty-eight hours with a perforated appendix and operated on under ether anesthesia. The patient had high leukocyte count. Fever went to 106 F. immediately after the operation, then to 108, and patient died the second postoperative day. Diagnosis was peritontis.

Case 7.—The patient was a female, age 11, sick seventy-two hours with perforated appendix, and operated on under spinal anesthesia. Temperature and leukocyte count were high. Seventy-five grains (5 Gm.) of sulfanilamide was used intraperitoneally at the time of operation. Postoperative program included Wangensteen drainage, fluids by mouth, intravenous fluids, and soapsuds enema. Temperature continued high. The patient died of general peritonitis on the fourth postoperative day.

Case 8.—The patient was a male, age 62, sick seventy-two hours, with gangrenous and perforated appendicitis; he was operated on under ether anesthetic, and 60 gr. (4 Gm.) of sulfa was used intraperitoneally at the time of operation. He had a high leukocyte count, distention, and vomiting. Postoperatively he was given fluids by mouth, Wangensteen drainage intermittently, fluids intravenously, and sulfa orally. He died of peritonitis on the fourth day.

Case 9.—The patient was a female, age 17, sick five days. At time of operation, the appendix was removed and found to be infected with pin worms. A small cyst of the ovary was removed. Cyclopropane anesthesia was used. The patient died of some type of cerebral involvement the fifth postoperative day and was signed out as as having a meningismus. This, however, was not a case of appendicitis.

Case 10.—The patient was a male, age 78, sick twenty-four hours with acute appendicitis with necrosis, and operated on under nitrous oxide anesthesia. Sulfa was used intraperitoneally, but no drainage was inserted. Following his operation distention developed. He was given fluids by mouth, Wangensteen drainage, intravenous fluids, and proctoclysis. An evisceration developed on the sixth postoperative day, and he died on the seventh. This was a right rectus incision closed with catgut in the presence of infection.

Case 11.—The patient was a female, age 24, sick six months with a condition diagnosed as chronic appendicitis. A right rectus incision was made under ether anesthesia. The appendix and the ovary were found in a mass of adhesions with a free fecalith in the peritoneal cavity. Sulfa was administered intraperitoneally, and the incision closed without drainage. Penicillin was given the first day, fluids

by mouth the second day, then a liquid diet. The pulse went up late the third day, and distention developed. Feeding by mouth was continued, and distention remained. The patients died of peritonitis on the ninth day.

CASE 12.—The patient was a female, age 64, sick forty hours with acute appendicitis with perforation and operated on under ether anesthesia. The patient had a high leukocyte count preoperatively. One hundred and fifty gr. (10 Gm.) of sulfa was used intraperitoneally, the abdomen was drained, Wangensteen drainage was used, fluids were given intravenously, and sulfa was given orally and intravenously. Postoperatively the patient was given fluids by mouth. Mayo enema and a saline enema were given. The patient was given a soft diet on the fifth day, and on the eighth day the Wangensteen drainage was discontinued. On the ninth day, because of abdominal distention, she was given hot packs and Mayo enema, and an hour or two later died of what was considered a pulmonary embolism.

CASE 13.—The patient was a female, age 74, sick five days of suspected chronic appendicitis, which was disproved by pathologic examination. The patient was operated on under spinal anesthesia. The leukocyte count was 15,000. There was albumin in the urine. The patient did badly following her operation. Bloody urine developed, and later a hemiplegia. The patient died on the sixteenth day.

CASE 14.—The patient was a female, age 11, sick four days with appendicitis with necrosis and pin worms and was operated on under spinal anesthesia. The child had a high leukocyte count and apparently a general peritonitis at the time of the operation. One million, two hundred and eighty thousand units of penicillin, sulfa, and transfusions were used. Later pelvic abscess was drained, but she died of general peritonitis on the thirty-sixth day.

In this group of 18 fatal cases, there were 6 patients who died within forty-eight hours: 4 that could definitely be classed as anesthetic deaths, 1 a possible pulmonary embolism, and 1 in which hyperthermia developed almost immediately after operation and probably could be termed an operative death.

There were 2 cases that were operative deaths in which the appendix appeared normal or was classed as chronic. There were 10 cases of perforated or gangrenous appendicitis in which peritonitis was the cause of death. In 5 of these distention was treated by repeated enemas, feeding by mouth was continued, and pitressin and pituitrin,—and in 1 a laxative—were given. Several had enemas preoperatively.

Thirteen had right rectus incisions; 5, McBurney.

Six of the deaths were among children 4 to 11 years of age, 1 was a child 14, 3 young people (17 to 24), 2 in the fourth decade, and 6 in the old-age group. One patient 78 years old had an evisceration on the sixth day. This is the only case of ruptured, gangrenous appendix which was closed without drainage.

Unfortunately, in this review the patients that were treated conservatively with so-called delayed treatment are not included. A period of preparation using large doses of penicillin and sulfonamides, decompression with the Wangensteen drainage, and administration of fluids intravenously would be an enormous advantage in some of these very sick patients with beginning peritonitis.

Recent mortality statistics in Wisconsin (1942-1946 inclusive) show 842 deaths attributable to appendicitis, with 197 in 1942, and 118 in 1946. This last figure is provisional. According to the state statistics there were 26 deaths in Rock County during that same period. Our survey reports 18 deaths. Eight deaths were eliminated because the appendix was removed incidentally in other types of surgery or the patient had died without operation and without proof that appendicitis caused the peritonitis.

Rock County has a population of 85,000, which is approximately 2.7 per cent of the population of the state. It had 3 per cent of the deaths from appendicitis. These surveys show the remarkable reduction in the over-all death rate from approximately 3 to 1 per cent. In one of the smaller hospitals 180 cases were reported in a four year period, with no deaths. Sulfa and penicillin therapy appear to be the principal factors in the reduction of the mortality rate. The group using the larger doses of penicillin shows the greatest reduction in the mortality rate. The committee sees a decided improvement in the records since the first survey was completed in 1941, and fairly accurate statistics are now available on 8,242 appendectomies covering a period of forty years.

In analyzing the 18 deaths that did occur it appears that in a certain percentage of cases in which the patient is extremely toxic with high temperature, preoperative treatment with doses of penicillin, Wangensteen drainage, and parenteral feeding should be given in order to avoid the tragic, immediate postoperative death. In cases of postoperative peritonitis with distention, it appears that elimination of fluids by mouth, continuous Wangensteen drainage, replacement of chlorides, maintaining proper water balance and protein metabolism, plus penicillin and sulfa therapy are the most important factors in treatment. Enemas appear to have no place in preoperative or postoperative treatment in the management of appendicitis. Anesthetic deaths are avoidable and should be eliminated by the improvement of the anesthetic service.

The problem of appendicitis appears to be more serious in the very young and the very old, and the most fatalities occur in the acute, suppurative, perforated appendicitis. Delay in operation is still one of the most important factors in the mortality rate, and while the public at large appears to be educated to the point where laxatives are seldom used, there is still evidence of the patient's failure to seek immediate medical advice when pain develops in the abdomen.

Therapy in Acute Infectious Disease in Children*

By J. P. CONWAY, M. D.
Milwaukee

J. P. CONWAY

A graduate of Washington University School of Medicine, St. Louis, in 1930, Doctor Conway entered Naval service in 1942; he was discharged with the rank of commander in 1946. He is now serving as assistant clinical professor of pediatrics at Marquette University School of Medicine. He is a licentiate of the American Board of Pediatrics

WHAT I have to say is anything but dramatic. The drama of therapy in infectious disease has long passed, at least until new discoveries are made. To give credit where it is due, we have to look to the originators of such milestones in medicine, as the discoverer of the micro-organisms, the many men who have stressed the need of maintaining an adequate water and electrolyte balance, the discoverers and investigators in the use of antitoxin and antisera, and the people who made the use of sulfonamides and antibiotics possible.

Confining myself to the field of pediatrics, it can be said that a practitioner now gets a great deal more sleep because of advances in therapy of infectious disease. I am sure that all of us have a greater sense of security in using the modern methods of treating such disease.

The usual procedure of such presentations is being reversed today, *i.e.*, rather than giving a historical sketch, and thereafter discussing the individual therapeutic measures, the oldest to the most recent, I am going to talk first of the most recent, and work backward, so to speak.

Shortly before streptomycin was made available in treating infectious disease, a laboratory director of a hospital in Wisconsin made the following statement to me. "Not so long ago the physician wanted to know what organism played a part in the etiology of a disease; now (since using penicillin) all that is desired is what color does it stain." Of course, that was an exaggerated viewpoint, but nevertheless, it does indicate a general letdown of interest in bacteriology by the average man in practice.

Streptomycin has been the curative agent in many cases of infectious disease, but, on the other hand, it has some very definite drawbacks. The indications for its use were so well discussed at this meeting last year, that I believe such a repetition would definitely be out of place.

The antibiotics, when used, should be given in massive immediate doses followed by a smaller maintenance dose. Furthermore, their administration should be continued after there is clinical evidence of cure by such standards as normal temperature, pulse rate, and respiratory rate, the return of appetite, increased fluid desire, and normal relaxed rest. The specific dosages have been purposely not mentioned, because there is a rather large margin of safety and the dose varies with the age of the child and with the disease being treated.

Even though there is a rather large margin of safety in dosage, there are toxic reactions which should be mentioned. Until very recently, it was not at all uncommon to find a macular rash following the administration of penicillin. Since the drug is more refined, crystalline form being used, this mild complication is not seen nearly as frequently.

One of the dramatic uses of streptomycin is in the treatment of influenzal meningitis. The drug, when given intramuscularly or intravenously, is very poorly absorbed into the spinal fluid. In treating any infectious process of the central nervous system, the drug must be injected intrathecally. Such a route of administration is definitely accompanied by dangers. Some authors believe that intrathecal administration of the drug causes a more frequent and early spinal block. I believe this is a controversial point and until definitely proved or disproved, it should not stop its use.

Streptomycin is definitely a toxic agent to the eighth nerve, but that should not inhibit its use in a disease caused by a streptomycin-sensitive organism when no drug can be substituted.

There is a lot of investigative work, clinical as well as laboratory, to be done in the field of antibiotics. I believe we should not worry too much as to the dosage, but rather through clinical judgment use the proper drug early.

As to the route of administration in children, intramuscular has been the most satisfactory. In order to maintain a desirable blood level, it must be injected every three hours. In infants and small children, there is not enough muscle tissue to serve as the absorption site for the preparation of penicillin in oil, or penicillin in oil and wax. Unless the usual precautions of sterility are taken, there is always the danger of infection; in the oil base preparation, a sterile abscess is more than an uncommon complication.

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

Recent reports of work done in the East indicate that huge doses of penicillin, such as 1,000,000 units in saline, injected once daily give the approximate blood levels as a lower amount, 300,000 units given in oil or oil and wax. This work was done on adults. I have never seen comparable work done on children.

To date, there is no satisfactory proved method of giving these antibiotics by the oral route. Remember, penicillin by mouth is an expensive bit of therapy of unproved value.

Recently I saw 6 nurses suffering from dermatitis venenata, the etiology in each case being streptomycin and the contact being the administration and dissolving of the drug. Of the 6 cases, the dermatitis in 4 cleared up immediately upon the discontinuation of the contact, in 1 after two weeks, and the sixth is still a patient after four weeks of treatment for the dermatitis.

Sulfonamides

Sulfanilamide was a wonderful drug at the time it was made available to the profession. It is now used very seldom, due to the knowledge and fear of its several toxic reactions. To me, the cyanosis which developed in many children taking the drug was the most frightening factor in its use. Even though the drug did reduce the mortality rate in certain infections, the other complications, such as depression of the urine and depression of the red bone marrow, made more investigative work a necessity.

As a result of this research, we have the many sulfa radicals on the market. All of these have been given their usual commercial build-up, but only a few have remained as common terms in our armamentarium of therapy, such as sulfanilamide, sulfadiazine, sulfamerazine, and sulfaguanidine.

In pediatrics, one of the most specific indications for the use of a sulfonamide is in the prophylactic therapy in rheumatic fever. There are varied opinions as to the effectiveness of its use in such situations; also, some men believe one radical is better than another. I sincerely believe that the recurrences of rheumatic fever can be reduced by the daily use of sulfamerazine. This drug should be given on an individual basis—in some patients each day of the year and in others started in September and discontinued in late May. The dose should be that which will maintain a blood level of from 2.5 to 3.5 mg. per hundred cubic centimeters. If the drug is given regularly and not in an overdose, reactions are very rarely encountered.

Sulfonamide therapy in the acute phase of rheumatic fever is definitely contraindicated because of the constant possibility of the presence of acute carditis. Sulfanilamide is definitely indicated in the complications of scarlet fever; many clinicians recommend its use also in the early stage of this disease.

The use of these drugs in conjunction with one of the antibiotics is definitely recommended in the early stage of many acute infectious diseases. Very often the combination of these two therapeutic agents will shorten the course over the use of either one separately.

Especially in children, we often have a clinical picture which is described as acute toxicity, with the appearance of a very red pharynx and with or without lymphadenitis. In these children a blood picture shows a leukopenia, with a relative lymphocytosis. It is dangerous to give such patients any of the sulfonamides because of the peripheral evidence of bone marrow depression. I do not know the true etiology of such clinical pictures, but with a low white blood cell count, I believe it would be far better to rely on the nonspecific use of the antibiotics, and general care, or simply supportive measures until the etiology can be determined.

Sulfadiazine is still the drug of choice in treating a patient for the prophylaxis of meningococcus meningitis.

The presence of any toxic symptoms of sulfonamide drugs, ever so mild, is a definite indication for its withdrawal. In treating such a toxicity, force fluids; transfuse if indicated; if anuria is present, wash out the bladder with warm alkaline solutions; or, if necessary, have the pelvis of the kidney washed with a warm alkaline solution.

The uroliths in the ureter caused by sulfanilamide can be rather easily washed out, while sulfadiazine crystals are usually precipitated in the tubules of the kidney.

Recently a recommendation has been made for the use of two or more sulfa radicals at the same time, hoping to obtain a better bacteriostatic effect, but remaining below the toxic level of each of the drugs. Such a therapeutic procedure very possibly has value, but I am sure work must be done before this can safely be accepted.

Although there is some difference of opinion as to the dosage of these drugs, the following plan is used by a great many clinicians. Give ⅓ to ½ gr. per pound of body weight as the initial dose, and about twice this amount divided in four or five doses for the remainder of the twenty-four hour period. For children, the weight is much more important than the age in calculating the dosage.

The sodium salts of these drugs can be administered subcutaneously as a 5 per cent solution. The blood levels of the drug rises to an optimum of 10 mg. per hundred cubic centimeters more rapidly, but the oral route seems still very effective.

Water and Electrolyte Balance

In acute infections the maintenance or replacement of a normal water and electrolyte balance is essential as a definite therapeutic measure.

The lack of such a normal balance not only causes even specific therapeutic measures to fail, but also makes the administration of certain drugs dangerous. Copious amounts of fluids should be insisted upon when giving sulfonamide.

Children, and especially infants, become dehydrated very early in infectious disease. Dehydration,

regardless of cause, results in a characteristic clinical picture. The child becomes restless, irritable, and, if the condition is not corrected, finally semistuperous. The skin takes on the well-known ashen gray color, loses its turgor, and feels dry. At first the child is excessively thirsty, but later he vomits anything taken by mouth.

Early in dehydration, the laboratory is of little help because the circulation is not impaired. Later the loss of fluid is reflected in an elevation of the blood count and hemoglobin, due to a loss of blood volume.

For a rational therapeutic approach to the fluid requirement of the body, the water content may be divided into two physiologic compartments, *i.e.*, the extracellular and the intracellular. The former includes the blood plasma, lymph, cerebrospinal fluid, and interstitial fluid. In an infant or a child this extracellular fluid constitutes roughly twice the proportion found in the body of an adult.

Intracellular fluid which is held within the cells as part of the protoplasm makes up roughly 50 per cent of the body weight.

Only in the basic water content are these fluids similar. Chemically there are marked differences. In short, the extracellular fluids contain large amounts of chloride, sodium, and bicarbonate, but small amounts of potassium, magnesium, and phosphate. Intracellular fluid, however, contains most of the potassium, magnesium, phosphates, and body protein.

The movement of water and the electrolytes between the two fluid masses is regulated by osmotic pressure, always by the transfer of water from the lower to the higher osmotic pressure.

In treating ill children and infants we must strive to maintain this normal osmotic pressure by replacing lost fluids and electrolytes; in other words, correcting acidosis or alkalosis. Correction of either of those pathologic states in their early stages is a rather simple procedure, but if allowed to proceed to where the intercellular balance is severely disrupted, *i.e.*, when there is a hemoconcentration, the return to normal is a difficult procedure. Any marked dehydration has the chemical and clinical picture of shock.

Whatever the cause of dehydration, fluids are needed to rehydrate the patient. When little or no fluids can be tolerated by mouth, the various forms of parenteral therapy are indicated.

The type of fluid and the method of administration will depend upon the condition of the patient. Physiologic saline is used to replace the electrolytes lost in the extracellular fluid. Lactate–Ringer's and Hartmann's solution have the added advantages of containing all the electrolytes of body fluids. After absorption the sodium lactate is metabolized into sodium bicarbonate. If one is unable to determine the carbon dioxide content or combining power, these solutions can be used with safety. This type of solution will combat acidosis much more readily than saline. Dextrose is commonly added to either solution for its food value or because of its antiketogenic effect.

Sodium bicarbonte or sixth-molar lactate solutions are used to combat very severe acidosis. However, the carbon dioxide content is the index for the use and amount. Either of these must be administered intravenously; sodium bicarbonate when the carbon dioxide content is 25 mg. per cent or lower and sixth-molar lactate for carbon dioxide content between 25 and 30 mg. per cent. I refer you to textbooks for the formula determining the exact dosages.

The amount of parenteral fluids used will depend upon the type and severity of dehydration. From 30 to 40 cc. per pound per day may be given subcutaneously. The subcutaneous route does not lend itself too well to the administration of dextrose. Intravenous fluids, whether they are normal saline, lactate–Ringer, dextrose, plasma, or blood, may be given up to 10 to 15 cc. per pound per day safely.

The rate of injection of intravenous fluids is as important as the amount given; from 3 to 5 cc. per pound per minute is a recommended rate. Certain drugs and biologicals may be added to these fluids.

Just a word concerning blood transfusions in acute infectious disease. At times it is necessary to administer whole blood, but it is best to correct the state of acute dehydration before this is given. This reasoning seems obvious.

The administration of amino acids plays a small role in treating infectious disease unless the patient has not taken a fairly normal caloric intake over a considerable period of time. These preparations have been improved considerably of late and now may be given either subcutaneously or intravenously. Remember, an amino acid solution is an excellent medium for the growth of bacteria, and therefore special care should be exercised to avoid contamination.

Mitchell–Nelson's text states that from one third to one half of the admissions for infectious disease to a pediatric hospital require parenteral fluids. I believe that this figure is high because fluids by mouth are not given early in adequate amounts.

Biologicals

This type of therapeutic agent covers a rather wide range. I must confine myself to that phase of biologicals, whether of human or animal source, which offer active antibodies for the control of specific disease.

We have at our disposal many biologicals which are of an unproved or disproved value in the treatment of disease. Two of these which enter my mind are vaccines used in the prevention and treatment of arthritis and rheumatic fever. Dictates from sound literature and experience deem these of no value.

This is about the time of the year commercial companies will contact us for the sale of vaccines, either oral or parenteral, used in the prevention as well as the cure of the common cold. I have never seen convincing proof of their values.

The work of Alexander and Fothergill on influenzal meningitis has produced a vaccine which has a very definite proved value. Although a very expensive piece of therapy, it has saved many lives. The dosage is determined by the sugar content of the spinal fluid, *i.e.*, the bacterial activity of the fluid. More recent work has shown that a combination of Alexander's serum with streptomycin and sulfadiazine has proved to be the best therapy.

We have at our disposal a very active biological of specific nature, *i.e.*, tetanus antitoxin, but this so often cannot be used when needed because of sensitivity of the patient to horse serum from previous injections. The antitoxin from the bovine source can be used in case of sensitivity to horse serum, but this is always of a very low potency. This is a very good reason for immunity through toxoids and continuation of this immunity by booster injections.

Human convalescent serum in the treatment of disease has made remarkable strides of late. We here in Wisconsin are fortunate to have the active serum center located in Milwaukee. This is not solely for Milwaukee physicians, but for use anywhere in the state when needed. These products are:

1. Scarlet fever immune serum
2. Measles immune serum
3. Mumps immune serum
4. Pertussis immune serum
5. Poliomyelitis immune serum

If convalescent serum is unavailable or undesired, gamma globulin will either attenuate or entirely protect an individual against measles. Gamma globulin seems also effective when used for these common nonbacterial infections in children in which leukopenia is a prominent feature. Gamma globulin has been reported to have shortened the course of infectious hepatitis.

Conclusions

1. Acute infectious disease in children demands active, immediate, complete therapy. Such therapy consists of repair of dehydration, chemotherapeutic agents, biological agents, and antibiotics.

SPRING CLINICS PLANNED FOR MARQUETTE SCHOOL OF MEDICINE ALUMNI

Dr. James M. Sullivan of Milwaukee has been named general chairman for the 1948 spring clinic of the Marquette University School of Medicine Alumni to be held May 13. During the afternoon session in the medical school auditorium, Dr. George Collentine, Philadelphia, will be presented the annual medical alumni award. The noon luncheon will be held in the Elizabethan Room of the Milwaukee Athletic Club.

Clinics at the Milwaukee County Hospital will comprise the morning program. These will be under the direction of Dr. Francis D. Murphy, department of medicine; Dr. Joseph M. King, department of surgery; Dr. Joseph M. Kuzma, department of pathology; and Dr. Jerome Marks, department of radiology.

The following papers will be presented at the afternoon session, to be held in the auditorium of the medical school:

"Gall Bladder Disease with Coronary Heart Involvement," *Drs. C. F. Broderick* and *John H. Houghton*, Wisconsin Dells

"The Control of the Cord Bladder," *Dr. Robert Irwin*, Milwaukee

"Cutis Grafts for Hernia," *Dr. Gervase Flaherty*, South Milwaukee

"The Diagnosis of Rheumatism," *Dr. Joseph Furlong*, Wauwatosa

"Carcinoma of the Lower Colon," *Dr. Irwin Schulz*, Milwaukee

"Thrombosis," *Dr. George Collentine, Jr.*, Philadelphia

"Treatment of Deafness," *Dr. Gerhard Straus*, Milwaukee

WISCONSIN TRUDEAU SOCIETY TO MEET IN MILWAUKEE ON MAY 16

The Wisconsin Trudeau Society will meet at the Hotel Pfister in Milwaukee on May 16. The program, which is open to all physicians who are interested, is as follows:

P. M.

1:00 "Papanicolaou Technique in Bronchogenic Neoplasm," *Dr. L. L. Swan*, Madison
Discussion by *Drs. J. R. McDonald*, Rochester, Minnesota, *J. Lubitz*, Wood, *J. Kuzma*, Milwaukee, and *G. Ritchie*, Milwaukee

1:50 "Tumors of the Mediastinum," *Dr. L. W. Paul*, Madison

2:15 "Differential Diagnosis of the Pneumoconioses," *Dr. O. A. Sander*, Milwaukee

2:40 "Non-Bacterial Pneumonias," *Dr. J. W. Brown*, Madison

3:05–3:15 Intermission

3:15 "Tuberculous Pericarditis," *Drs. D. Feld*, Wauwatosa, and *R. Jahn*, Milwaukee
Discussion by *Dr. F. Rosenbaum*, Milwaukee

P. M.

3:40 "Empyema: Medical and Surgical Treatment," *Drs. F. Raine*, Milwaukee, and *G. Owen*, Milwaukee

4:05 "Pulmonary Function," *Drs. T. R. Murphy*, Wauwatosa, and *A. Bond*, Madison

4:30 "Spontaneous Pneumothorax and Mediastinal Emphysema," *Dr. Helen A. Dickie*, Madison

4:55 Business Meeting

6:45 Dinner Meeting, Hotel Pfister

8:00 "The Diagnosis and Treatment of Congenital Heart Disease," *Dr. Willis J. Potts*, Chicago
Discussion by *Dr. J. W. Gale*, Madison

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Therapy of Pulmonary Embolism

Small pulmonary emboli may produce only substernal pain, faintness, coughing, or bloody sputum, but a massive embolus may result in sudden death. In these latter cases the signs of complete circulatory dissolution are due not only to sudden obstruction of the pulmonary arterial tree but also to intense vasospasm of the unaffected part of the pulmonary artery, to sudden coronary insufficiency, and to bronchial spasm. In a nonfatal pulmonary embolism the symptoms of precordial pain, dyspnea, cyanosis, and other features similar to those of myocardial infarction may make differential diagnosis difficult. However, diminished voice and breath sounds and moist rales are frequently heard over the involved portion of the lung, pleural friction sounds are often heard, and there may be hemoptysis. Allen *et al.* (1943) found it a point of considerable differential diagnostic value that in the vast majority of instances the lower lobes of the lungs are involved more frequently than the upper. It is said that there are certain electrocardiographic signs that may be pathognomonic, especially soon after the embolus has lodged, but the roentgenologic signs are often very ill-defined during the first twenty-four hours. The degree to which pulmonary embolism may simulate other conditions was emphasized by Sagall *et al.* (1945), in whose study of 162 episodes in 108 cases it was found that the total clinical picture simulated pneumonia, angina pectoris, acute myocardial infarction, pleurisy, vascular collapse, or acute heart failure in a large percentage of instances.

De Takats and Fowler (1945) reiterated what the senior author had pointed out several years earlier, namely, that about 60 per cent of patients with fatal emboli live from one hour to several days, which means that in the majority of instances there is sufficient time to institute treatment for the episode itself. Certainly, no matter what else is subsequently done, the inhalation of oxygen in high concentration is the most valuable immediate therapy. In earlier studies De Takats and his associates had concluded from animal experiments that a widespread radiation of autonomic reflexes occurs during embolism, affecting the heart, the pulmonary-vascular tree, the bronchi, and the gastrointestinal tract. These reflexes being predominantly vagal, and hence producing spasm of smooth muscle, the use of atropine and papaverine is indicated. De Takats and Fowler (1945) feel that morphine may sensitize the vagus and therefore is contraindicated in pulmonary embolism, and that epinephrine may lead to pulmonary edema in the presence of an increased pressure in the pulmonary arteries such as exists in cases of pulmonary embolism. De Takats therefore gives 1/75 grain (0.8 mg.) of atropine sulfate hypodermically immediately and a second dose intravenously shortly thereafter if the first dose has not caused flushing of the face and dilatation of the pupil; in any case ½ grain (30 mg.) of papaverine hydrochloride is also given intravenously. The atropine and papaverine administration is repeated three or four times a day. De Takats has continued to employ this atropine-papaverine measure with satisfaction for a number of years at his hospital.

Meigs and Ingersoll (1946) said that all the surgeons of the Massachusetts General Hospital are convinced that interruption of the femoral veins is essential after a sublethal embolus or infarct. De Takats (1947) said that when the origin of the embolism is recognizable he ligates above the level of the thrombus, which may be at the superficial femoral, the common iliac, or the vena cava. When the origin of the embolus is unknown, he does not use phlebograms but institutes anticoagulant therapy, *i.e.*, 50 mg. of heparin intravenously at four-hour intervals for two days, plus dicumarol in adequate amounts to maintain the prothrombin level at least 50 per cent below normal. He warned that when one stops the administration of the anticoagulant drugs this must be done gradually.—HARRY BECKMAN, M. D.

WISCONSIN CHAPTER OF INTERNATIONAL COLLEGE OF SURGEONS TO MEET

Members of the Wisconsin Chapter of the International College of Surgeons will hold a dinner meeting at the University Club of Milwaukee on April 28. Papers will be presented by the following physician members:

"Surgery of the Rectosigmoid," *Dr. W. J. Carson*, Milwaukee

"Diagnostic and Therapeutic Management of a Difficult Surgical Case: Repair of Large Postoperative Ventral Hernia," *Dr. V. F. Marshall*, Appleton

"Fenestration Operation for the Improvement of Hearing," *Dr. G. D. Straus*, Milwaukee

"Hightension Line Injury: Electric Burn," *Dr. N. E. Bear*, Monroe

"Wilms Tumor; Case Report," *Dr. L. C. Pomainville*, Wisconsin Rapids

. . . . THE PRESIDENT'S PAGE . . . .

Mind and Body

PSYCHOSOMATIC medicine has come into its own. The psychic origin of somatic disease is no longer in the realm of mythology. Modern psychology is accorded the same relation to psychiatry as physiology has to general medicine. If this is accepted, it means that psychology is the study of the cellular function of neurogenic tissue in its relation to other tissues and cells of the body—in short, the physiology of the brain and other central nervous system elements.

The physical concept of the origin of neuroses and psychoses may be objected to on the basis that years of diligent search have failed to find either gross or microscopic change in the central nervous system tissue in these diseases. However, the absence of a method or methods by which physical changes in the cellular elements of neurogenic tissue can be detected is no proof that they do not exist.

To the majority of the physicians, a physical approach to the understanding of mental disease is realistic. The absence of verifiable evidence that this is true and an unwillingness to accept undefined "psychic origin" as an explanation for pathologic behavior or to believe that pathologic behavior is a disease, have delayed until recent years the recognition of clinical psychology and psychiatry for a prominent place in medical school curriculums.

However, psychic trauma, whatever it may be, is now recognized and accepted as a cause of mental as well as somatic disease. The difficulty is that its general recognition as a factor in disease has come about suddenly, and, as a result, there are very few practitioners in the field of clinical psychology and psychiatry.

The demand for these specialists is much greater than the supply. Recognition of this need occurs largely among professional personnel of the military, the Veterans Administration, the medical profession, and a small group of lay citizens responsible for the administration of hospitals for mental diseases. An extension of the use of the methods employed in these two fields of medical practice and the training of a larger group of these specialists are urgent. This will require a large educational effort on the part of some group and a reorientation of the thinking of physicians with reference to the control, prevention, and treatment of mental diseases.

At this point in our development it is natural that volunteer groups of citizens in our state are concerned with the cause and treatment of mental diseases. One such organization deserving of cooperation on the part of the medical profession is the Wisconsin Society for Mental Health. Its officers and leaders are well versed in the problems confronting Wisconsin in the care of the mentally ill and preventive programs designed to rehabilitate potential patients for our mental institutions. Organizations of this character have an important role to fill, as the public is in great need for education in this important but still relatively unexplored field of medical care.

W D Stovall

As It Looks From the Blue Cross Viewpoint

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

L. R. WHEELER

Executive Secretary
of
Associated Hospital
Service, Inc.

John Q. Public is not a doctor nor is he a hospital administrator, but he is sick occasionally and needs medical care. If he needs an operation, or if his case is severe, you send him to a hospital. John may be a farmer, a plumber, or the proprietor of a business, but, regardless of his occupation, he has given little thought to who operates a hospital—or why. He takes both the doctor and the hospital for granted and never thinks of them until they are needed. Then he is likely to be very demanding because he suddenly needs the professional services of a man and of an institution about whose existence he is hardly aware. He may feel it to be a life and death issue, so, regardless of the time of day or night, he wants you to come to his house right away. Also, regardless of the per cent of occupancy of the hospital, he can see no reason why there isn't room for him.

All of the above is, of course, not news to you, as you meet that situation frequently. I believe it does, however, point out that the medical profession and hospitals and their respective organizations have an opportunity to correct the erroneous thinking of the public relative to health economics.

Your patient has confidence in you, or you would not be his physician, so it follows that your advice as to his joining a prepaid plan of hospital and/or surgical-medical care may be very well received. He would be interested to learn from an authoritative source that you, through your own Medical Society, are operating a plan whereby he may, for few cents a day, protect himself and his family against the catastrophic costs of ill health. This is as it should be; no person, agency, or organization, including the government, can actually furnish the surgical-medical services he needs but you—the doctor. Your prepaid surgical-medical plan, as you know, is now known as the Blue Shield Plan, and is actually operated by yourselves—the medical profession.

In order to keep administrative costs at rock bottom and to provide both surgical-medical care and hospitalization to the public with but a single payroll deduction, your society has entered into an arrangement with the Blue Cross Plan whereby Blue Cross acts as selling and collecting agent for you. Blue Cross has no voice in policy making, setting of membership fees, scheduling of benefits, or acceptance or rejection of claims; it merely acts under your orders in selling your plan and collecting your money. All publicity pertaining to the Blue Shield Plan is approved by your organization. By this arrangement, the medical profession and the hospitals, through their Blue Shield—Blue Cross Plans, are presenting the people of Wisconsin a united program of health services on a professionally controlled and operated nonprofit basis. This arrangement permits an extremely low overhead expense and thereby enables both Blue Shield and Blue Cross to offer greater benefits for each dollar in membership fees than is possible through any other means.

This pooling of activities has resulted in a very brisk demand for both Blue Shield and Blue Cross. In the short space of approximately two years, more than 200,000 persons have voluntarily joined Blue Shield, and approximately 675,000 persons have joined Blue Cross in eight years. From these figures it is seen that the demand for Blue Shield is as brisk as for Blue Cross. The fact that about 20 per cent of the entire population of Wisconsin has within eight years availed itself of the nonprofit type of prepaid health service proves conclusively that this type of protection is most acceptable to the public.

In view of the tremendous number of people enrolled in this program, it is only natural to conclude that problems will arise in its administration. Many of us do not study our life insurance policies, deeds, mortgages—yes, and even our Blue Shield-Blue Cross contracts. We, therefore, sometimes are of the opinion that their terms and conditions are somewhat different than they really are. We also find that in many instances your patient brings you his Blue Shield or Blue Cross contract and expects a complete explanation and analysis. Both the Blue Shield and the Blue Cross organizations earnestly hope you will not hesitate to contact them whenever you have a question pertaining to any part of either contract.

(Continued on page 402)

Both Blue Shield and Blue Cross insist that the existing physician-hospital-patient relationship be preserved. This is as it should be, but it does occasionally present problems that must be solved. For example, some people feel that Blue Shield and Blue Cross membership should prepay all of their doctor bills in the home and office as well as in the hospital, and should pay all of their hospital bills. No doubt both organizations would like to be able to do just that, but quite obviously it would be out of the question, not only because of cost, but also because it would materially alter the customary practice of medicine. It is axiomatic that if the fee is sufficiently high, one can obtain protection against almost any contingency, but by raising the fee to the necessary level, a large portion of the potential membership would not feel it could afford to join. We therefore have to provide benefits that can be offered at a price the public will pay. Some subscribers and a few physicians question the fact that Blue Cross does not pay for purely diagnostic cases, but to do so would overload the hospital facilities, be excessively costly to the Plan, and last, but not least, would tend to take patients to the hospital that could just as well be taken care of in your office. Also, if such services were included, both Blue Shield and Blue Cross would in a great many instances be providing periodic health examinations and checkups. From a standpoint of public health, such benefits would be fine, but economically the Plans could not include them.

A number of physicians have stated that patients sometimes demand hospital care, even though unnecessary, just because they have Blue Cross. We recognize that this presents a serious problem to you, but I am gratified to report that even in view of such requests, the vast majority of physicians do not admit patients unless hospital care is actually necessary. There are a few isolated cases in which the physicians accede to the requests of the patients. If good medical practice indicates that hospitalization is necessary, we want the patient hospitalized, but, on the other hand, if such care is not necessary, we will appreciate your cooperation.

With the continued active cooperation of the medical profession and the hospitals, your Blue Shield and Blue Cross Plans will continue to provide their services to an ever-growing membership in Wisconsin, and thereby not only will be of invaluable assistance in assuring the medical profession and the hospitals of their fees, but will also preserve the private practice of medicine and the voluntary hospital.—L. R. WHEELER.

INTERN AND RESIDENT ASSOCIATION OF THE MILWAUKEE COUNTY HOSPITAL TO MEET MAY 1

Members of the Intern and Resident Association of the Milwaukee County Hospital will meet at the hospital on May 1. Following morning and afternoon sessions in the hospital assembly hall, a dinner will be held at the Hotel Pfister. The program, which has been arranged by Drs. J. Kuzma, H. L. Correll, and L. J. Tauber, is as follows:

A. M.

10:00 "Non-Surgical Treatment of Tic Douloureux," Dr. L. W. Ramlow, internist, Milwaukee

10:30 "Use and Abuse of Estrogens," Dr. J. A. Klieger, instructor in obstetrics and gynecology, Marquette University School of Medicine

11:00 "Interpretations of Serological Reactions for Syphilis," Dr. J. M. Lubitz, pathologist and director of laboratories, Wood

11:35 "Thirty Years of Public Health," Dr. J. W. Mountin, assistant surgeon general, U. S. Public Health Service, Washington, D. C.

12:30 Lunch and Business Meeting

P. M.

2:00 "Significance of a Medical Education," Dr. J. S. Hirschboeck, dean, Marquette University School of Medicine

2:35 "Use of Newer Cardiac Drugs," Dr. W. L. Coffey, senior resident, internal medicine, Milwaukee County Hospital

3:05 "Therapy With Antibiotics," Dr. D. R. Nichols, clinical staff, Mayo Clinic, Rochester, Minnesota

3:50 "Practical Aspects of Lumps in the Breast," Dr. J. G. Garland, chief of Milwaukee County Hospital Surgical Division

6:00 Dinner, Hotel Pfister, Dr. L. J. Van Hecke, Toastmaster

"Selected Illustrations—Before and After," Dr. C. D. Bradley, obstetrician, Newport News, Virginia

"Twenty-Five Years in the Vineyard," Dr. F. D. Murphy, director of medicine, Milwaukee County Hospital

The
MEDICAL FORUM

The Wisconsin Medical Journal — April, 1948

PURCHASE HOME FOR THE STATE MEDICAL SOCIETY

SOCIETY'S NEW HOME—Above is the building recently purchased by the State Medical Society of Wisconsin for its offices. It is located at 704 East Gorham Street, Madison. The Society will not move in for several months.

Offices May Move Into New Building in October

Madison, March 8.—A home for the State Medical Society of Wisconsin became a reality with the announcement that arrangements for the purchase of a 2½ story brick building located at 704 East Gorham street in Madison had been completed.

The building, constructed about 30 years ago, is a substantial, attractive structure located on property on the shores of Lake Mendota. Purchase of the building had been under consideration for several months by a committee appointed by the general Council of the society. It was necessary to secure an amendment to the present zoning laws of Madison to permit such activities as those of the society to be conducted in the location.

The society expects to begin occupation of its new home shortly after the annual meeting or sometime in October. At the present time, the society has its main offices in the Tenney Building on capitol square. Offices of the Wisconsin Veterans Medical Service agency and Wisconsin Physicians Service, both agencies of the society, are located in the Washington Building on East Washington Avenue.

The new quarters will permit the main offices and those of the agencies to be united in one building. Space will also be available for a meeting room for the Council and society committees.

The need for a home for the society has increased with growing activities of the society requiring more space than is now available and the necessity for bringing all the activities of the society under one roof. Rising rental costs for three offices in two buildings were also a prominent factor in the decision to purchase a home.

AMCP Enlarges Staff With Budget Increase

Chicago, Mar. 11.—With an increased budget for 1948, estimated at nearly $65,000, Associated Medical Care Plans (AMCP) has expanded its office staff and services.

Since the adoption of Blue Shield as the official insignia of non-profit prepayment medical care plans, AMCP is also known as The National Association of Blue Shield Plans, and the governing board is called the Blue Shield Commission.

AMCP, formerly housed in the AMA headquarters, moved to larger offices of its own on January 1, 1948. Two additions were made to the secretarial staff, and Lynn Doctor and John Castellucci, both from Michigan Medical Service, joined the staff. Mr. Doctor is a statistician. Mr. Castellucci, former director of Veterans Care Program of Michigan Medical Service, is assisting with the development of home town veteran's care programs which are administered by Blue Shield plans and also acts as a special assistant to Frank E. Smith, director of AMCP.

Send Questionnaire for Study of Group Practice

Chicago, March 22.—Widespread interest in group practice, particularly on the part of physicians who were in service during the war, has caused the AMA's advisory committee on group practice to map plans for a comprehensive study of the subject.

The committee met recently with the director of the Bureau of Medical Economic Research of the AMA to start plants on the study. The study was authorized by the House of Delegates at the June meeting in Atlantic City in 1947.

ON THE INSIDE

	Page
Board of Health Study	6
Chronic Ill and Aged	3
Compulsory Health Report	4
Industrial Clinic	2
Industrial Medicine	5
Legislative Council	8
March of Medicine	7
National Health Assembly	6
Rural Doctors	2
School Health Bill	3
Secretaries' Conference	6
Wisconsin Plan	5

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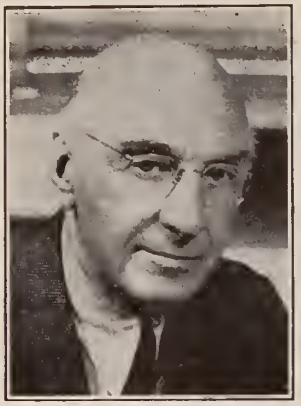

Dr. V. G. Heiser

Dr. O. A. Sander

STATES SUPPLY CASH, DESIGN COURSES TO BRING FUTURE DOCTORS TO COUNTRY

The problem of how to bring physicians to rural areas and keep them there has brought action from medical men and legislatures in several states.

Their ideas range from scholarships and grants to general practice courses in medical schools, preceptorships and post-graduate courses.

A joint $100,000 plan for financing medical education for farm boys in Illinois was recently announced by the Illinois State Medical Society and the Illinois Agricultural association. Each organization is contributing $50,000 to a revolving fund from which loans will be made to accepted medical students at the rate of $1,000 a year to a maximum of $5,000 per student.

Must Go to Rural Areas

Students seeking loans must agree to return to practice in a town of less than 5,000 population and repay the money in five annual payments after they begin practice. The students must be recommended by the local medical society and farm bureau. The cosponsors expect to have 20 students financed from the fund by 1957.

In Mississippi, the state legislature established a medical education scholarship loan program from which a student may borrow $1,250 per school year with a $5,000 maximum. In return he is to practice in a rural area for at least two years. If he stays five years or longer his loan is discounted at one fifth of his total loan per year. Under this plan, 94 students are beginning or continuing medical training this year.

A program to keep general practitioners abreast of latest progress in medicine has been started by the Pennsylvania Medical society. Under its guidance, the state's medical centers have put 150 instructors on the road to teach one 8-hour class a week for 10 weeks. Of the 840 doctors in the opening course, 580 were general practitioners, mostly from rural areas.

Emphasize Education

Kentucky, Virginia, North Carolina, Maryland and Alabama are also utilizing the scholarship method of inducing doctors to practice in rural areas.

In Michigan and Minnesota the emphasis is on education. Michigan's varied program includes lectures on rural medical practice to senior students; a rural residency training program; a "visiting program" in which members of the medical school faculty provide monthly consultations to each hospital, and a two-year general residency program.

Minnesota has internships and preceptorships in general practice and favors requiring general practice before permitting graduate training in the specialties.

Write for Booklet

Louisiana sponsors yearly 10-week review courses in the various specialties for the benefit of rural practitioners, and Nebraska is starting preceptorships to rural practitioners whereby students who have completed their junior year will "look over the shoulder" of the older physician as he practices rural medicine.

A review of the over-all picture of rural medical service in America is given in a recently published booklet prepared by the Committee on Rural Medical Service of the AMA. These booklets may be had upon request to the State Medical Society.

HEISER, SANDER TO ASSIST WITH INDUSTRIAL CLINICS

Dr. O. A. Sander, Milwaukee, will serve as one of the medical consultants for the fourth of a series of county industrial health clinics, to be held at the Gisholt Machine Co., Madison, May 6.

Dr. Victor G. Heiser, New York City, author of "An American Doctor's Odyssey," will speak at the Racine county industrial clinic on April 21. Dr. Heiser has achieved international fame for his work in industrial medicine.

Clinics have already been held by the Rock County Medical Society, with the Fairbanks–Morse plant in Beloit acting as the industrial "guinea pig" on March 31, and the Outagamie–Winnebago county clinic with the Fairview Paper Mill, Neenah, serving as the plant demonstration on April 15. A third clinic will be held at Racine on April 21 with the Massey–Harris plant as the demonstration center.

The Madison clinic will serve the Dane County Medical Society and neighboring communities. It will include a tour of the Gisholt plant in the afternoon, followed by a discussion of industrial hazards and their control by Dr. Sander and Dr. Paul A. Brehm, director of the industrial hygiene division of the State Board of Health. Mr. Harry Nelson, director of the workmen's compensation division of the Wisconsin Industrial Commission, will discuss the estimation of permanent disability in industrial injuries.

The dinner meeting at the Park Hotel, Madison, will conclude with brief talks by Dr. Sander and Mr. Nelson.

The clinic will serve as the regular May meeting of the Dane County Medical Society. Any physicians outside the county interested in attending the clinic are invited to do so by making reservations through the office of the State Medical Society, 917 Tenney Building, Madison 3, Wisconsin.

School Health Bill Would Give 'Free' Care to More Than 30,000,000 Children

Saltonstall Bill Called Socialization Measure

Washington, Mar. 15.—Hearings on a school health services bill calling for federal aid to states to provide for the prevention, diagnosis and treatment of physical and mental conditions of more than 30,000,000 children between the ages of five and 17, were held on March 8–9.

Seven witnesses testified on the bill, known as S. 1290, the National School Health Services Act of 1947, and introduced by Senators Saltonstall, Smith, Fulbright, Lodge, Baldwin and Ives. It has the hearty endorsement of the Parent–Teachers Association.

The bill provides that subsidies be paid the States through the Children's Bureau of the Federal Security Administration to "establish and develop school health services for the prevention, diagnosis and treatment of physical and mental defects and conditions of children." Observers say that under the bill, all school children could receive medical, dental, nursing and hospital care at public expense from salaried public health personnel.

No Limit On Cost

As it stands, the bill calls for an appropriation of $10,000,000 for the first year, $15,000,000 for the second year and no limit is set on future expenditures under an "open-end" clause.

Oscar Ewing, administrator of FSA and the first witness on the bill, introduced several amendments which considerably changed its content. As a result, the bill now includes "all youth of school age," the program is changed to "develop in each state . . . a comprehensive school health program . . . for all children and youth of school age, pursuant to an integrated state plan which includes supervision of health instruction, physical education programs, school health services, and school health examinations."

The amendments also gave the FSA administrator, now Mr. Ewing, full administrative authority and power to appoint the 12 man "national advisory committee on health services."

Dr. James R. Miller, member of the AMA Board of Trustees, supported the principle that the best facilities for the prevention and diagnosis of disabling conditions in children should be undertaken, but from a state level, not a national level. Referring to the omission of a means test, lack of personnel, and other objectionable provisions, he said the AMA must withhold approval of the bill.

Testifying in favor of the bill was Dr. John P. Hubbard, director of the study by the American Academy of Pediatrics on the health of school children. He proposed that Congress appropriate $5,000,000 to provide grants-in-aid by the FSA to train pediatricians.

Dr. Hubbard said the Academy is not "altogether free" of the fear that Federal dollars for medical education may bring with them Federal interference in the policies of teaching institutions." He added that if Federal funds are to be used to strengthen the teaching of doctors, the "medical profession should take an active part in formulating the plan and assuring that Federal support does not mean Federal dictation."

Dr. Martha Eliot, of the Children's Bureau, and Dr. Reginald Atwater, executive secretary of the American Public Health association, also endorsed the bill at the hearings. Dr. Vlado Getting, health commissioner of Massachusetts, suggested two separate bills.

Committee Acts to Help Infirm and Chronic Ill

Madison, March 21.—Efforts to improve the care of the chronically ill and aged in the state's institutions were continued by the Committee on Mental Hygiene and Institutional Care at a meeting here under the chairmanship of Dr. H. H. Christofferson, Colby.

The committee, including Dr. B. J. Hughes, superintendent of Winnebago State Hospital and Dr. O. H. Epley, New Richmond, and Drs. W. D. Stovall, director of the state laboratory of hygiene and W. J. Urben, director of mental hygiene of the department of public welfare, met with Mr. A. J. Thelan, secretary of the Wisconsin County Boards Association.

This was the first of a series of meetings to refine provisions of a bill introduced but not acted upon in the 1947 legislature. That bill provided for establishment of county or joint-county infirmaries for the treatment, care and maintenance of the aged infirm and chronically ill. The state would have paid the county for the full cost of caring for each state-at-large patient and one-half the cost of all other patients.

Future meetings are planned with the county boards, county judges and asylum superintendents associations and with the department of public welfare with a view to making the bill more workable and its benefits available to a greater number of counties.

The committee emphasized that real progress in the care of these patients depended upon better coordination of state and federal laws on the subject and a re-study of methods of financing public welfare work.

The quality of medicine which is at our beck and call cannot be valued in dollars and cents. If it could be, the price would be most reasonable.

However, when the doctor bill does arrive, it sometimes looks like the national debt to the individual who has to pay it in a lump sum.

Accident and Health, Hospital and Surgical Insurance helps soften the blow and keeps the patient on a paying basis.

It is our aim to pay all claims promptly. The attending physician can make his patient's disability insurance more efficient by the prompt dispatch of claim blanks covering the disability.

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TO THE RESCUE—Dr. Daniel Dorchester, Sturgeon Bay, (left above) is a life-saver in more ways than one. He is shown with K. S. Reynolds, vice-president of the State Chamber of Commerce, just after they completed an air rescue of three fishermen adrift on an ice floe in Door County waters. Dr. Dorchester has several hundred hours of flying time to his credit and often travels to medical meetings by air.

Figures Show Economic Outlook for Hospitals

Hospital Director Speaks

Milwaukee.—The necessity for a clear understanding of "certain fundamental facts" before arriving at a decision on the economic status of hospitals was emphasized by Dr. Roger W. DeBusk, executive director of the Evanston (Ill.) Hospital association, at a meeting of the Wisconsin Hospital association on February 19.

He cited the following statistics as having an important bearing on thinking on the subject:

"10% of the population goes to the hospital each year;
Capital investment in the nation's hospitals is 5½ billion dollars;
Annual budget of all hospitals is 1½ billion dollars;
93% of those requiring hospital care go to general hospitals;
99% of our babies are born in general hospitals;
86% of all out-patients are cared for in general hospitals;
77% of all charity cases are handled in general hospitals."

Dr. DeBusk pointed out how the cost of hospital care has remained nearly the same since the turn of the century although the average length of stay has declined.

He said that "in 1900 the average per diem cost of hospitalization was $3.00 per day. The average length of stay, however, was 30 days. Net cost of hospitalization illness, $90.00. In 1940 the average cost was $9.00 per day and the average length of stay was 10 days, net cost of hospitalized illness, $90.00. Today, the average cost is $14.00 and the average length of stay 7 days, again net cost of hospitalized illness amounts to nearly $90.00."

Dr. DeBusk outlined the part of the government, industry, philanthropy and the patient in the support of the nation's hospitals.

Middleton Renamed to Advisory Post with VA

Washington. — All members of the Veterans Administration national advisory group on medical problems, including Dr. W. S. Middleton, Madison, have accepted reappointment by Carl R. Gray, Jr., administrator of veterans affairs, the VA has announced.

Dr. Middleton had been appointed to the group by Gen. Omar N. Bradley, former VA administrator. Chairman of the group is Dr. Charles Mayo of the Mayo Clinic, Rochester, Minn. The group advises the administrator and Dr. Paul B. Magnuson, chief of the VA's department of medicine and surgery, on over-all policies concerning medical service to veterans.

Brookings Report Sees Too Much Politics in Federal Medicine

Washington, D. C., Mar. 15.—Compulsory national health insurance would involve too much politics and government control, the Brookings Institution has reported after an extensive study of the problem.

The report has been submitted to the Senate Labor Committee. On the matter of compulsory health insurance it said:

1. Such a system would "necessitate a high degree of governmental regulation and control over personnel and the agencies engaged in providing medical care."
2. "It does not seem probable that politics could be eliminated from medical care supplied under a governmental system."
3. A "real danger" exists that government intervention would impair the relationship of practitioner and patient.
4. Administration "would require thousands of government employees for accounting, auditing, inspection and investigation."
5. "The cost of medical care presumably would increase."

Impartial Study

Senator H. Alexander Smith, R–New Jersey, chairman of the senate subcommittee on health, last summer asked the Brookings Institution as an impartial agency to make a study of health conditions in the United States and the possibility of their being improved by enactment of either the Taft Bill (S. 545) or the Wagner–Murray–Dingell Bill (S. 1320). So far only the "Conclusions and Recommendations" of the 400-page report have been made available to the subcommittee, but the full report is due by May 1.

The Brookings report said that for the time being the federal government should direct its aid toward research, school health education, teaching of preventive medicine, acquiring physical facilities and training personnel and providing care for the indigent. It said that it would be wise to leave to the states the question of adopting a compulsory system.

Wisconsin Plan Adds 375 Doctors to List of Participating Physicians and Surgeons

Madison, Mar. 31.—Nearly 375 physicians and surgeons have added their names to the list of doctors participating in the Wisconsin Plan of prepaid surgical, obstetric and hospital care. This raises to more than 2,150 the number of doctors taking part in this plan.

Almost 200 of the added group of Wisconsin Plan doctors are in Milwaukee county with the remainder from the state at large.

The Wisconsin Plan is a health insurance policy accepted and approved by the State Medical Society and sold by more than 20 licensed insurance companies in Wisconsin. It currently has more than 100,000 persons enrolled.

New Benefit Schedule

The committee on extension of insurance which supervises the plan has announced that revised objectives, principles, specifications of coverage and fee schedules will go into effect on May 31. Printed material explaining these changes is in the process of being published.

A new "question and answers" booklet explaining the Wisconsin Plan for doctors, insurance men and the public will soon be distributed to all physicians in the state and will be available for others to read.

At the same time, a new master schedule of benefits and a revised list of the participating physicians will be available. The new list of participants will include nearly 100 osteopathic physicians and surgeons.

Gains in Farm Groups

The Wisconsin Farm Bureau, whose organization of associated women is sponsoring a health improvement program, reports that 23 counties each have more than 100 Wisconsin Plan policies in Farm Bureau groups. Four other counties are about to complete their drives for membership in the Wisconsin Plan.

According to Hal Kautzer, health director for the Farm Bureau, these counties represent the most heavily populated farm areas of Wisconsin and the response of Farm Bureau members has been "excellent."

AMA Sets Up Residency In Industrial Medicine

Chicago, March 30.—The most promising step yet taken toward satisfying the evergrowing demand for physicians qualified in industrial medicine was the establishment of requirements for a residency in industrial medicine at the June, 1947 meeting of the AMA House of Delegates.

The criteria for residencies in occupational medicine have been prepared by the AMA Council on Medical Education with the aid of the American Association of Industrial Physicians and Surgeons. They define the character of industrial medicine in its four major divisions: health conservation, medicine and surgery, environmental hygiene and administration.

No definite steps have yet been taken toward American Board cerfication in Occupational Medicine, but there is a possibility that certification will be established in the future, according to Dr. E. W. Brown, assistant secretary, of the AMA Council on Industrial Health. The present work in the field is didactic rather than clinical, he said.

Inplant medical organizations and affiliated hospital and laboratory services will be necessary to provide enough instruction in industrial medicine to produce a sufficient quantity of trained personnel.

Affiliated hospitals, individuals or institutions which consider themselves qualified to provide this kind of training are to apply to the Council on Medical Education and Hospitals for approval.

Davis Opposes Legion Plan on Vet Hospitals

Wants One System for All

Indianapolis.—Graham L. Davis, president of the American Hospital association, has called upon the American Legion to reconsider its stand on the expansion of the veterans' hospital program and to promote instead the integrated hospital system for everyone—including veterans—under the hospital survey and construction act.

In a conference with James F. O'Neil, national commander of the American Legion, Mr. Davis pointed out that the act enables the states to furnish adequate hospital, clinic and similar services "to all their people."

"One purpose of the program is to get doctors and nurses to rural areas by providing them with adequate facilities. The veterans hospital program works in the opposite direction by constructing hospitals in comparatively few places, the larger centers of population as a rule, where such units may not be needed."

He added that by paying higher salaries and building large hospitals the VA will draw away from rural areas many of the doctors, nurses, technicians and other personnel who are now there.

Mr. Davis stated that the Legion is proposing to build a hospital system of 300,000 beds which is "far in excess of the needs of all veterans." Within 15 to 20 years, he said, the nation will have 300,000 more beds than it needs if both the VA and Hospital Survey programs of construction continue. He predicted that these empty beds would be used as an excuse for compulsory health insurance by "a Leftist government."

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LEGISLATURE ASKS SOCIETY'S HELP TO STUDY STATE BOARD OF HEALTH

Special Committee Will Present Recommendations

Madison, March 20.—The legislative committee studying the state departments and services has asked the State Medical Society for help in "modernizing" the State Board of Health.

The committee, headed by Senator Gordon A. Bubolz, Appleton, adopted a resolution asking the society to appoint a special committee which will meet with the board of health, make its own investigations, and collect information needed to make recommendations to the legislature.

The study committee is to report suggestions for legislation that will permit the improvement and further development of the State Board of Health's effectiveness in the solution of public health problems in Wisconsin. It is hoped also that the study will reveal methods that would tend to clarify administrative procedures and assure maximum efficiency of this agency.

The resolution said in part:

"Whereas the State Medical Society of Wisconsin and its county societies have long taken interest in the formal public health activities of the State of Wisconsin, and sponsored the original measure creating the State Board of Health, as well as many subsequent proposals relating to its organization, structure and responsibilities,

"Be it therefore resolved that this committee request the State Medical Society of Wisconsin to provide the advice of a special committee composed of individuals skilled in public health administration, organization technics, business management, and general health projects, with such committee requested to cooperate with the State Board of Health and its personnel and such other persons as may be designated by this subcommittee for the purpose of presenting concrete and detailed proposals to effectuate the purposes outlined in this resolution . . ."

The Society's Council on Medical Service and Public Relations has been asked to appoint the special committee and will announce the members within the near future.

Complete Plans for U.S. Health Assembly

Five M. D.'s on Committee

Washington, D. C., Mar. 30.—Plans for the National Health Assembly called by Federal Security Administrator Oscar Ewing for May 1 to 4 in the nation's capitol have been expanded to include sections on industrial hygiene and environmental sanitation.

Ewing added four more physicians to the executive planning committee for the assembly after his original appointment of 24 persons, only one of whom was a physician, created a furor in medical circles. Now, in addition to Dr. George F. Lull, secretary and general manager of the AMA, the committee includes Drs. R. L. Sensenich, AMA board of trustees; E. L. Bortz, AMA president; Paul R. Hawley, executive head, Blue Cross and Blue Shield, and Vlado A. Getting, president, State and Territorial Health Officers.

Washington sources report that President Truman is preparing another health message which he will deliver to Congress in the near future. It is believed this message will announce to Congress the program which Administrator Ewing plans to develop at the National Health Assembly. He has been asked by Truman to formulate a 10-year health program.

Reaction to the announcement of plans for the assembly is varied.

An AMA editorial asked: "Is the new national health assembly to be simply another sounding board for a leftist medical program?"

The *Chicago Tribune* published stories concerning what it termed the political aims of the conference. One story was based on an interview with Dr. Morris Fishbein, editor of the AMA Journal, who raised the question as to whether the assembly is to be "a scientific conference or a political brawl."

"One might reasonably question," Dr. Fishbein was quoted as saying, "whether propaganda for the Truman health program is to be built up for use before the political conventions."

TO GET INSIDE VIEW

The State Medical Society of Wisconsin will be well represented at the National Health Assembly called by FSA Administrator Oscar Ewing for May 1–4 in Washington.

At least four members of the Society and the secretary will attend the meeting from Wisconsin. Dr. R. G. Arveson, Frederic, chairman of the Council on Medical Service and Public Relations, will pick those who are to sit in on the meeting.

Recalling his own attendance at a similar national health conference in 1938, Dr. Arveson told the delegates, "Only by seeing the Federal Security Administration and the proponents for socialization at work can you realize the tremendous pressure being brought to bear for compulsory health insurance."

Secretaries' Meetings to Be Held in May and June

Madison, March 26.—A series of four secretaries' conferences designed for the secretaries, presidents and other officers of county medical societies, delegates and councilors, chairmen of county public relations committees and interested physicians, is being planned by the Council on Medical Service and Public Relations, Chairman R. G. Arveson, said.

The conferences will be an effort to bring county society officers into closer acquaintance with state society activities and to call their attention to medical-economic affairs and public relations practices.

Notices have been sent to county officers informing them of the dates and locations of the meetings:

Fond du Lac, May 26, for county societies in the first, second, fifth, sixth and twelfth councilor districts.

Baraboo, May 27, for county societies in the third, fourth and seventh councilor districts.

Wausau, June 2, for county societies in the eighth, ninth and thirteenth councilor districts.

Rice Lake, June 3, for county societies in the tenth and eleventh councilor districts.

Meetings will get under way at about 4 p.m. and will last through the dinner hour until 8:30 or 9 p.m. Those attending will be dinner guests of the State Medical Society.

March of Medicine Ends Third Year as Radio Program

23 Stations Now Carry Society's Health Talks

Madison, April 1.—Happy birthday to The March of Medicine! The State Medical Society and the State Board of Health joined today in greetings to the society's weekly radio health broadcast and the eleven radio stations which have carried the program for three consecutive years.

Six stations are being honored for their contribution to public health by carrying the programs for 2 years and five stations for having just started the program or for carrying it for more than a year. All will receive certificates of recognition.

Commendations for three years of service in bringing reliable and practical health information to Wisconsin's citizens went to WATW (Ashland), WJMS (Ironwood), WKHB (La Crosse), WIBA (Madison), WOMT (Manitowoc), WMAM (Marinette), WIGM (Medford), WJMC (Rice Lake) and WLBL (Stevens Point). Stations WEAU (Eau Claire). WTAQ (Green Bay) will complete three years within a few months.

Stations carrying the program for two years are WHBY (Appleton) and WEMP (Milwaukee). Stations KFIZ (Fond du Lac), WIKB (Iron Mountain), WHBL (Sheboygan) and WSBR (Superior) will soon complete two years.

Appleton	WHBY	Sat.	11:30 a.m.
Ashland	WATW	Sat.	8:15 a.m.
Eau Claire	WEAU	Tue.	4:00 p.m.
Fond du Lac	KFIZ	Sat.	8:15 a.m.
Green Bay	WTAQ	Sat.	2:00 p.m.
Iron Mt.	WIKB	Sat.	8:15 a.m.
Ironwood	WIKB	Sat.	8:15 a.m.
Kenosha	WJMS	Sat.	11:15 a.m.
La Crosse	WKBH	Thu.	5:30 p.m.
Madison	WIBA	Sat.	8:30 a.m.
Manitowoc	WOMT	Sat.	10:15 a.m.
Marinette	WMAM	Sat.	9:15 a.m.
Marshfield	WDLB	Fri.	11:15 a.m.
Medford	WIGM	Fri.	11:15 a.m.
Milwaukee	WEMP	Sat.	11:45 a.m.
Neenah	WNAM	Wed.	10:15 a.m.
Oshkosh	WOSH	Sat.	11:15 a.m.
Rhinelander	WOBT	Mon.	2:45 p.m.
Rice Lake	WJMC	Tue.	4:00 p.m.
Sheboygan	WHBL	Tue.	7:15 p.m.
Stevens Pt.	WLBL	Mon.	11:30 a.m.
Superior	WSBR	Sat.	9:15 a.m.
Waukesha	WAUX	Fri.	1:15 p.m.

BIRTHDAY CAKE—Dr. Llewellyn R. Cole, who writes and presents "The March of Medicine," takes the first cut at a birthday cake with candles representing the three years the program has been on the air. The State Medical Society staff looks on.

The March of Medicine has been on the air for more than a year at WDLB (Marshfield) and WOSH (Oshkosh). The program was added to the schedule of WOBT (Rhinelander) about two months ago, and stations WLIP (Kenosha) and WNAM (Neenah) will soon complete a year's service. Beginning April 23, station WAUX, (Waukesha) will carry the program.

The program began with 10 stations participating and has grown to 23 station coverage within three years. Growing public interest in the program is evidenced by the fact that "fan mail" has increased to 10 times the amount received in the first year. Listeners have written-in from 67 counties representing more than 300 communities and from Michigan, Iowa, Minnesota and Illinois.

The March of Medicine is carried as a public service feature by the 23 stations. Most of the programs are informal talks given by Dr. Llewellyn R. Cole, coordinator of graduate medical education at the University of Wisconsin, covering such subjects as goiter, heart disease, acne, pneumonia and overweight.

Occasionally guest speakers appear on the program with Dr. Cole. Recent interviews have been held with Miss Ione M. Rowley, State Board of Health, on public health nursing; Mr. T. J. Doran, director of Wisconsin Veterans Medical Service Agency, on veterans care and Mrs. C. D. Partridge, executive secretary of the state nurses association, on nurse recruitment.

The program is written by Dr. Cole, except when interviews are held, and the mechanics of keeping the program going and arrangements for special broadcasts are made by Mrs. Mary B. Davis of the society staff.

On the basis of mail received from this program, Dr. Cole has prepared a talk on "What the Public Thinks of its Doctors" which he presents to county medical groups upon invitation.

Dr. Cole interviews Miss I. M. Rowley, State Board of Health, about public health nursing problems.

The Senate has killed President Truman's No. 1 reorganization plan which would have transferred the United States Employment Service and all federal unemployment compensation activities to the Labor Department. The program ran into opposition because it would have given organized labor almost complete control of the conditions under which an unemployed worker must accept a job or under which he could draw unemployment compensation benefits.

* * *

The House Rules Committee voted against the U. S. becoming a member of the World Health Organization. Many of the American republics have also held off, following our leadership, and if they do not join, probably not enough countries will join to keep the Organization alive.

* * *

Hearings on S. 545 and S. 1320 (the Taft bill and the WMD bill) will not be resumed until after April 19. Senator Murray will be away from Washington until that date and Marjorie Shearon, for whom the hearings were postponed because of illness, will also be away until early April.

* * *

More than a million dollars has been allocated to Wisconsin for cancer research and control, the U. S. Public Health Service has announced. $975,000 is for a cancer research unit, $19,000 is for a tumor clinic, and another $24,000 is for research on various related subjects. All the grants were made to the University of Wisconsin.

* * *

Rep. R. W. Kean (R., N. J.) has introduced a bill that would bring virtually all wage earners, including servants and farm workers, under the federal old-age insurance system. The Social Security Administration tells Congress that now is the time to enact a comprehensive program to insure all Americans against economic insecurity.

COMMENTS FROM THE WISCONSIN PRESS

A potent argument for the continuation of the free enterprise system in medicine was advanced recently by the Wausau *Record-Herald* in an editorial published in the March 16, 1948 issue of that newspaper. Permission has been granted to reprint the article here in full.

"CRITICISM OF A PHYSICIAN"

'Many physicians do dodge the making of calls on patients in the late hours of the night or early morning,' the American Medical association's Journal has asserted in commenting on recent complaints of this nature from many sections of the country. It points out that the physician is free to choose whom he will serve, but it also notes that in some cities an exchange exists which does service night calls and finds physicians who will respond to such calls.

This question naturally brings to mind the fact that there are some physicians who in years past did their utmost to reach the country home in cooperating with the stork, while in more recent years the stork has been given orders that he must drop his little bundles in hospitals instead of in far off country homes.

Nevertheless there are emergencies in which the patient cannot readily be moved from his home. There are also some older physicians whose waning strength prevents them from making the hazardous trips they once made. What is highly desirable in all calls for physicians' help is a sincere understanding between the physician and his patient. In other words, the physician who refuses to respond to a sick call from one of his faithful patrons, merely on the basis of inconvenience, should, at least, try to arrange for another physician to make that call if he is to retain the confidence of that patron. If the patron is willing to wait for the physician to personally make the call that is an indication that the call is not too urgent.

While a physicians' exchange may help in these matters, the patients' confidence in his family physician is often too strong to allow too free a substitution of doctors. After all, the very fact that a family physician has learned to know a case thoroughly through attendance on that patient is a very strong reason why the visit of a doctor to whom the case may be strange is apt to be disappointing to the patient.

This is one of the reasons why governmentally sponsored medical practice is apt to be unsuccessful, and for this reason, the individual physician should do all in his power to protect the patient under the free enterprise system.

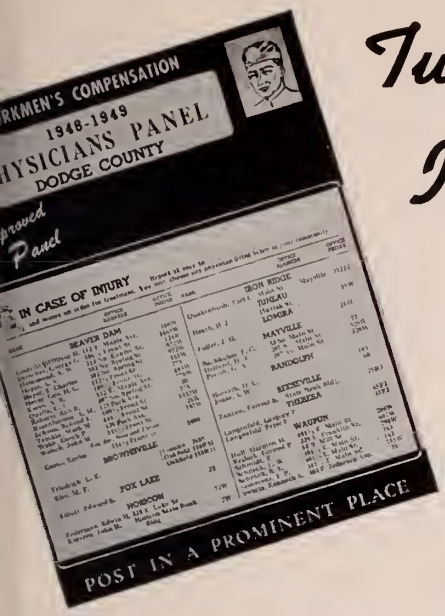
Wisconsin Legislative Council Finds Facts, Studies State's Problems Between Sessions

A development of major importance in the 1947 legislature was the creation of the Wisconsin Legislative Council to keep its finger on the pulse of the stae's governmental problems between sessions on the pulse of the state's governdigging for facts, conducting surveys and research and giving advance consideration to problems expected to come up when the legislators returns to their capitol seats in 1949.

Twenty-three other states have such councils so the idea is not new. Wisconsin's council has 12 members—five senators and five assemblymen, not more than one of whom can be from the same congressional district, and two assemblymen appointed from the state at large.

The council usually meets on the second Monday of each month. Its chairman is Senator Warren P. Knowles, New Richmond; Assemblyman Alfred R. Ludvigsen, Hartland, is vice-chairman, and Senator Gordon A. Bubolz, Appleton, is secretary. Mr. Phillip S. Haberman, Madison, is director of the office in the capitol.

Other members of the council are Senators Gustave A. Buchen, Sheboygan; Edward F. Hilker, Racine, and Jess Miller, Richland Center; and Assemblymen Grover L. Broadfoot, Mondovi; Milton F. Burmaster, Wauwatosa; John D. Heimick, Milwaukee; Paul A. Luedtke, Wausau, and Raymond A. Peabody, Milltown.



Two Important Publications for benefit of SMS MEMBERS

COMPENSATION PANELS

All employers covered by Workmen's Compensation insurance have been supplied with panels carrying the names of SMS members who have indicated a desire to participate in the program. These panels will be in force during 1948–49.

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INDUSTRIAL GUIDE

Here is a new publication by the Committee on Industrial Health of the State Medical Society of Wisconsin and the Industrial Hygiene Unit of the State Board of Health which is *free to all members of the State Medical Society, industrial nurses, and top management.* Just send the coupon at the bottom of this page, either pasted on a penny postal card or enclosed in an envelope addressed to the State Medical Society of Wisconsin, 917 Tenney Building, Madison 3, Wisconsin.

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« « « EDITORIAL » » »

Introducing the Guest Editorialist

Again this year, The Wisconsin Division of the American Cancer Society is fortunate indeed to have one of the state's outstanding industrialists as its campaign chairman. Mr. Oscar T. Jacobsen of Racine is ably carrying forward the program for fund raising which was so vigorously conducted last year by Mr. Walter Kohler, Jr. The officers of The Wisconsin Division are confident that they shall again exceed their goal under Mr. Jacobsen's wise and efficient leadership.

Oscar T. Jacobsen is president of the Jacobsen Manufacturing Company, manufacturers of power lawn mowers and home water systems. He is also president of the company's two subsidiary organizations, the Johnston Lawn Mower Corporation of Ottumwa, Iowa, and the Worthington Mower Company of Stroudsburg, Pennsylvania.

Upon receiving his discharge from the United States Marine Corps in 1919, Mr. Jacobsen joined his father in the Jacobsen Manufacturing Company as vice-president and secretary, becoming president at a later date upon the death of his father.

Mr. Jacobsen is affiliated with many civic and fraternal organizations and has done effective work for the general good by serving as a member of the city school board and the city planning commission. He belongs to the Racine Chapter of the Aeronautic Association and at different times he has held membership in the Rotary and Lions Clubs. He is also a member of the American Legion and the Veterans of Foreign Wars, being a past commander of the latter, and he is a Knight Templar Mason and Shriner.

Mr. Jacobsen's editorial shows a keen awareness of the cancer control problem and an appreciation of the dual responsibility of the medical profession and the laity.—R. O. McLean, *Executive Director, Wisconsin Division, American Cancer Society.*

This Partnership

IN DISCUSSING cancer control with members of the Wisconsin medical profession, I am reminded of the fact that, in reality, all of us are voluntary partners in an increasing effort to effect a relief for cancer. During the month of April, a host of new partners are enlisted through the national drive for funds conducted by the American Cancer Society and supported by individuals and industries of all descriptions.

To the layman, cancer is the most dreaded of the remaining widespread afflictions. As its diagnosis has improved, this disease has penetrated the circle of family or friends of an increasingly large segment of our people. It is a tribute to the medical profession that cancer has few companions in the category of disease for which adequate treatment is still not available. It is a tribute to the people of this country that during the month of April many thousand men and women will give their time and many millions will give financial support in order, voluntarily, to assist in overcoming a serious national deficiency.

The partnership between the medical profession and the layman is joined by the American Cancer Society which, through its organizations in each state, directs the raising of funds from the public and the allocation of those funds to projects considered by medical people to be worth while. In Wisconsin, financial support is given to the McArdle Memorial Institute of the University of Wisconsin for the study of nutrition and its effect on the growth of cancer. In addition, each July, clinics for the discussion of recent developments in cancer diagnosis and treatment are held at several locations throughout the state. Finally, postgraduate teaching in various phases of cancer at the McArdle Memorial Institute is in part supported by funds made available through the Society.

Each of the partners in this endeavor has definite responsibilities. Speaking, at the moment, for the public of which I am a member and for the American Cancer Society which I represent, it is our responsibility to insure that progress is not retarded by reason of insufficient funds. It is also our responsibility to teach the people of this country the necessity for early diagnosis of the disease and to keep the people informed and interested in the developments in treatment that result from medical research and practice. These responsibilities we will undertake gladly.

The ultimate relief, of course, must come through the knowledge, the skill, and the labor of you men of the medical profession. You are the partner upon whom the final responsibility rests. However, as your efforts go forward it may be encouraging to know that you have the enthusiastic support of the other partners in our common enterprise, support which will reveal its strength through the results of the fund-raising drive this month of April.

O. T. Jacobsen

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

The Cephalin-Cholesterol Flocculation Test, the Thymol Turbidity Test, and the Thymol Flocculation Test

(Continued from last month)

The Thymol Turbidity Test[3]

Principle.—Abnormal sera when brought together with a buffered thymol solution results in the precipitation of a complex containing protein, thymol, cholesterol, and a phospholipid of lecithin type. The degree of turbidity is measured by comparing the solution after one-half hour with the formazin standards devised by Kingsbury and associates.[14]

Preparation of Thymol Buffer, p^H 7.8, $\mu = 0.01$.

1. Add 500 ml (cc.) of distilled water to 1.38 gm. of barbital, 1.03 gm. of sodium barbital, and approximately 3 gm. of thymol.
2. Heat just to boiling, shake well, and cool thoroughly.
3. The mixture, which should now be turbid, is seeded with a small amount of powdered thymol crystals, is shaken, and is allowed to stand over night at a temperature of 20 to 25 C.
4. Shake well again the next morning (to avoid supersaturation) and filter the clear solution from the crystalline deposit.

It should be noted that it is not possible to shorten this preparation by weighing out exact amounts of thymol, because there is some interaction between the thymol and the barbital on heating, perhaps esterification, and an excess of thymol must be present to insure saturation. The solubility of the thymol is significantly reduced below 20 C. and the buffer should, therefore, be stored in a warm place in cold weather. It has been found by Cohen and Thompson[8] that the reagent may develop a turbidity on standing after seven to ten days. Reheating, cooling, and again seeding with thymol crystals results in a clear solution.

Procedure.—

1. Measure 0.1 ml. (cc.) of serum into a tube the same size as the tubes containing the formazin standards of Kingsbury and associates.
2. Add 6.0 ml. (cc.) of buffer.
3. Allow to stand one-half hour and compare in a comparator with a black line on a white background against the Kingsbury standards.
4. When the turbidity exceeds the 100 mg. per cent standard, dilute with a further measured volume of buffer as required. Results are expressed in arbitrary units equal to the appropriate standard divided by ten with allowance for dilution.

The standard dilution is 1 to 60, so that if the final dilution is 1 to 120 and the mixture then matches the 70 mg. per cent tube, the result is 14 units.

Expressed as a formula:

$$\text{Units} = \frac{\text{Standard tube reading} \times \text{final dilution of serum}}{600}$$

Normal limits are 0 to 4. Inactivated sera cannot be used, because the reaction is partly abolished by heating to 56 C. for thirty minutes. Formazin turbidity standards of Kingsbury and associates are not easy to prepare, but they can be purchased from the Fales Chemical Company, Cornwall Landing, New York, or the A. S. Aloes Company, St. Louis, Missouri. It is important to check standards every few months against diluted serum of known protein content, using 1 volume of diluted serum to 3 volumes of 3 per cent sulphosalicylic acid.

The Thymol Flocculation Test[11]

Eighteen hours after the thymol turbidity reading a flocculation often occurs and can be read like a cephalin-cholesterol flocculation test.

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(Continued on page 423)

An Announcement

on

Blood Chemistry Service

to

Physicians in Wisconsin

The increased demand for blood chemistry has exhausted our operating funds for this service. In the present fiscal period ending June 30, 1948, we are confronted with a deficiency. This is due mostly to an increased amount of work both in quantity and in quality. The increased cost of supplies and materials, and expansion of service in the nature of additional tests are added elements in the increased cost of operation. The quantity increase is illustrated by the following:

Year	No. of Specimens	No. of Analyses
1943	24,358	39,588
1944	28,296	45,984
1945	30,859	48,951
1946	38,526	61,107
1947	46,288	73,387

Incidentally, in an effort to keep pace with scientific advances many additional chemical determinations have been added. During the last year 1,443 special determinations were made upon request by practicing physicians of the following nature: cholesterol, calcium, bilirubin, icteric index, total protein, albumin, globulin, potassium sulfacyanate, phosphorus, acid and alkaline phosphatase, amylose, chloride, sodium, and potassium.

This expansion in our service to the medical profession was made possible by the appointment of Dr. Frank Kozelka to our staff.

Blood chemistry for clinical purposes was started as a service to physicians, hospitals, and institutions of Wisconsin by the Wisconsin Psychiatric Institute about twenty-five years ago. The cost of this service is met by legislative appropriation. A blood preservative making possible these examinations on specimens shipped through the mail was developed by the Wisconsin Psychiatric Institute and remains the approved method at the present time. In rendering this service the Institute supplies the vials containing the preservative, ships vials to physicians, hospitals, etc., upon request; makes chemical determinations as requested by the physician; and reports the results without fee or charge for any part of this service. The aid that blood chemistry brings to diagnosis and treatment, the assumption that such blood chemistry was not readily available to all physicians in Wisconsin, and the further fact that prompt diagnosis and good medical care of physical conditions would perhaps prevent mental diseases justified this as a practical effort in prevention. It is further believed that this service should be continued and certainly without loss in quality. Unless the insufficiency of operating funds is met in some manner, it may be necessary to place a ceiling upon the quantity of work. Under no circumstances will the quality be permitted to suffer.

While an effort will be made to economize wherever possible, it is probable that another and perhaps greater deficiency will occur in the fiscal year beginning July 1, 1948 and ending June 30, 1949; therefore it is proposed to have the physician or hospital shoulder a part of the operating cost. The postage to ship prepared vials and mail reports totals approximately $1,500 per annum. If this item of expense is borne by the one receiving the service the predicted deficiency in operating funds would be cut practically in half.

Six cents in postage is required for the shipment of four prepared vials. Three cents in postage covers the mailing of the report. We, therefore, propose the following:

1. **When a physician, hospital, or institution requests vials for the shipment of a specimen for blood chemistry 6 cents in postage should accompany the request.**
2. **When a specimen is sent in for chemical analysis either 3 cents in postage should accompany the specimen or, preferably, a stamped envelope addressed to the sender.**

This defraying of postage by those being served will start on May 1, 1948.

If, and when, funds again become available to carry on as in the past twenty-five years, an announcement to that effect will be made.

W. F. LORENZ, M. D.
Director

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A. R. ZINTEK

Doctor Zintek, a native of Milwaukee, received his M. D. degree from Marquette University School of Medicine in 1934. In 1947 he received the degree of D.P.H. from the University of Michigan following three years of postgraduate work in epidemiology, during which he served also as resident lecturer and research assistant in poliomyelitis. He was appointed to his present post of director of preventable diseases in July 1947.

The Value of Placarding in the Control of the Common Communicable Diseases

The philosophy for the need of community action in the control of the common communicable diseases has been firmly established. However, the application of such practices must constantly be evaluated in the light of newer knowledge, changes inherent in the biology of disease and experience.

Chapin was constantly concerned with evaluating practices directed toward the control of infectious disease. There was little parallel between the strong psychic action of the odoriferous terminal fumigants and their effect on destroying the etiologic agents of infectious disease. Their place has been taken by the use of ultraviolet light and the various aerosols which are effective within certain limitations of sterilizing the air of enclosed spaces such as operating rooms, classrooms, theaters, etc.

Efficacy of Prompt Treatment

The introduction of the sulfonamides has made it possible to render a case or carrier of meningococci non-infectious within forty-eight hours after the institution of treatment. The use of adequate dosage of penicillin renders a gonococcal infection non-transmissible within an interval of a day. The successful development of the newer antibiotics now being investigated in many laboratories suggests that prompt treatment of many infections offers a very powerful tool in their control.

Experience has indicated that the people of London, who fled from plague, which Daniel Defoe describes so vividly, accomplished little more than to carry the infectious processes with them and to establish new foci in other areas of the British Isle. Still today we see the tendency for a mass exodus of persons from areas where poliomyelitis is prevalent. It raises a serious question of whether they too may not be responsible for the establishment of new foci of infection in the areas to which they move. The tendency of people to run away from epidemic areas has been replaced by the sound practice of isolation.

Shortcomings of Placarding

The value of the practice of isolation of a person known to harbor a transmissible infectious agent has been firmly established. Recently, however, a good deal of thought has been given to the value of designating such homes by the use of a placard or quarantine sign. Its basic premise is established on the assumption that such a sign, tacked on a home, serves as an effective warning to others not to enter. Furthermore, it has been said to be justifiable because it prevents visitors from carrying new infections into the home which could then be superimposed upon the already sick individual.

Experience, however, indicates that the effective use of a placard sign is handicapped by very serious limitations. Many diseases are transmissible before they can be recognized and a placard established. Moreover, the incidence of mild, atypical, or missed cases are so frequent in some diseases that placarding homes of diagnosed cases represents only a small portion of the entire problem. In many instances the effective spreader is a carrier who can not be recognized unless laboratory procedures are used. The processing of cultures and smears is not always practicable under all circumstances.

As the result of such experience the Committee on Administrative Practices for the Control of Communicable Diseases of the American Public Health Association has recommended that the practice of placarding serves little purpose and should be discontinued for many diseases. In their recent and separate report the Committee on Therapeutic Procedure for Acute Infectious Disease and on Biologicals of the American Academy of Pediatrics has published a similar recommendation.—ARTHUR R. ZINTEK, M. D., *Director, Preventable Diseases.*

AMERICAN COLLEGE OF CHEST PHYSICIANS SETS EXAMINATION DATE

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Chicago on June 17. Candidates who would like to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

"Spring Clinics"

- LA CROSSE ..... JUNE 1
- WAUSAU ..... JUNE 2
- MANITOWOC ..... JUNE 3

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Program Chairman

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ARTHUR A. SCHAEFER, M. D.
Assistant Clinical Professor of Surgery
Marquette University School of Medicine
"Problems in Pediatric Surgery"
Clinical Case Study in Pediatrics

WILLARD O. THOMPSON, M. D.
Clinical Professor of Medicine
University of Illinois College of Medicine, Chicago
"Androgen and Estrogen Therapy"
"Present Status of Treatment of Toxic Goiter"

PATHOLOGICAL CLINICAL CONFERENCE

In the late afternoon of each clinic the local county medical society will present a pathological clinical conference, with all four members of the faculty as participants. This will be a new feature of the "Spring Clinics" and promises to be of special interest to those in attendance.

Register!

The registration fee of $4.00 will cover the noon luncheon and defray, in part, the expenses of speaker honorariums and publicity. The balance will be withdrawn from the treasury of the State Medical Society from funds provided the Council on Scientific Work for scientific teaching programs.

(USE REGISTRATION SLIP ON BACK PAGE OF INSERT)

SOCIETY PROCEEDINGS

Brown—Kewaunee—Door

Members of the Brown–Kewaunkee–Door County Medical Society met at the Beaumont Hotel in Green Bay on March 11 to hear two guest speakers from Milwaukee. *Dr. William H. Frackelton,* from the department of surgery at Marquette University School of Medicine, presented a paper on "Salvaging the Injured Hand," illustrating his talk with slides and colored film. Mrs. Libbie Rose, of the Milwaukee Curative Workshop, spoke on the Curative Workshop and also showed a colored film in connection with her subject. A curative Workshop Advisory Committee has been appointed to work in conjunction with the board of directors of the workshop now being organized at Green Bay.

Chippewa

Lantern slides were used to illustrate a talk by Dr. E. S. Judd, Jr., of Mayo Clinic when he spoke at the meeting of the Chippewa County Medical Society at Hotel Northern in Chippewa Falls on February 17. He entitled his talk "Surgical Treatment of Duodenal Ulcer."

Columbia—Marquette—Adams

J. M. SULLIVAN

Mr. Robert Steiner, Baraboo, was present at the March meeting of the Columbia–Marquette–Adams County Medical Society at the Hotel Portage in Portage on March 9 to discuss the Wisconsin Plan of Prepaid Hospital Insurance. *Dr. H. E. Gillette,* Pardeeville, also reported on the immunization program at this meeting.

The February meeting of the Society was held on February 10 at St. Savior's General Hospital in Portage. Following a regular business session, *Dr. James Sullivan,* professor of surgery at Marquette University School of Medicine, spoke on "Surgery of Peripheral Vascular Disease."

Douglas

"Carcinoma of the Gastrointestinal Tract" was the subject for discussion at the meeting of the Douglas County Medical Society at Hotel Superior in Superior on March 3. Dr. L. L. Merriman of Duluth, Minnesota, was the guest speaker. *Dr. Margaret Hatfield,* Ashland, district health officer, discussed the child guidance center.

Eau Claire—Dunn—Pepin

Dr. Mancel T. Mitchell of Minneapolis was the guest speaker at the Eau Claire–Dunn–Pepin County Medical Society when it met at the Elks Club in Eau Claire on February 23. Doctor Mitchell spoke on "Obstetric Hemorrhage."

Fond du Lac

J. E. GONCE, JR.

Hotel Retlaw in Fond du Lac was the meeting place for the Fond du Lac County Medical Society on February 26. *Dr. John E. Gonce, Jr.,* professor of pediatrics at the University of Wisconsin Medical School, spoke on "Practical Aspects of the Rh Factor."

Dr. G. A. Cooper, Madison, talked at the March meeting of the Society, which was held at the Hotel Retlaw on March 18. Doctor Cooper, who is assistant professor of dermatology at the University of Wisconsin Medical School, chose "Diagnosis and Treatment of Common Skin Diseases" as his subject for discussion.

Jefferson

Members of the Jefferson County Medical Society met at the Cottage Hotel in Lake Mills on March 18, to hear a discussion on the organization and function of the State Medical Society and its agencies. Mr. C. H. Crownhart, executive secretary of the Society, discussed its functions, and Mr. Thomas J. Doran and Mr. Ralph Weber explained the work of the Wisconsin Veterans Medical Service Agency and Wisconsin Physicians Service respectively.

La Crosse

"Management of Head Injuries: Diagnosis and Treatment" was the title of a paper presented by Dr. Alfred Uihlein, Rochester, Minnesota at a meeting of the La Crosse County Medical Society at The Fireside in La Crosse on February 10. Doctor Uihlein used lantern slides to illustrate his presentation.

Manitowoc

Members of the Manitowoc County Medical Society gathered at the Hotel Manitowoc on February 26

to hear an address by *Dr. J. L. Sims* of Madison. Doctor Sims, who is associate professor of medicine at the University of Wisconsin Medical School, spoke on "Liver Diseases."

Monroe

Movies on traumatic surgery were shown at the February meeting of the Monroe County Medical Society when it met at St. Mary's Hospital in Sparta on February 17. *Dr. H. H. Williams, Jr.*, Sparta, presented a paper on "Gas Gangrene and Traumatic Wounds."

Outagamie

Dr. Everett H. Brooks, celebrating his fiftieth anniversary in the medical profession, was honored by the Outagamie County Medical Society at a testimonial dinner on March 18 at the Conway Hotel in Appleton. Approximately eighty members and guests attended to pay tribute to the doctor, who has practiced in Appleton since August 1902. Judge Michael G. Eberlein of circuit court presented the main address at the dinner. Other speakers were *Dr. J. B. MacLaren*, Mr. F. J. Sensenbrenner, Mr. Karl Stansbury, and *Dr. W. D. Stovall*, president of the State Medical Society.

The Outagamie County Dental Society joined the Outagamie County Medical Society for a meeting at the Conway Hotel in Appleton on February 19. Dr. Wayne B. Slaughter, from the University of Illinois College of Medicine, spoke to the group on "Newer Concepts of the Treatment of Hare Lip and Cleft Palate."

Portage

Dr. Sture A. M. Johnson, professor of dermatology and syphilology at the University of Wisconsin Medical School, spoke at a meeting of the Portage County Medical Society held at the Hotel Whiting on February 24. His paper was entitled "The Diagnosis and Therapy of the Common Dermatological Conditions."

Racine

Drs. Eugene Pitts and *K. W. Covell* were hosts to the members of the Racine County Medical Society at an open house in their new offices in Racine on March 18. The open house preceded a dinner meeting at the Racine Country Club. The subject of discussion for the evening was "The Emergency Treatment of Head Injuries," *Dr. Harry Maxwell*, Milwaukee, presenting the surgical aspects, and *Dr. Harold Cook*, superintendent of Milwaukee County Emergency Hospital, presenting the medical aspects. The program of hearing tests for school children as sponsored by the Bureau for Handicapped Children of the State Board of Health was approved.

Sheboygan

L. M. SIMONSON

Meeting at the St. Nicholas Hospital in Sheboygan on February 24, members of the Sheboygan County Medical Society heard a talk by *Dr. L. M. Simonson*, Sheboygan. His paper was entitled "Congenital Heart Disease."

Richland

Dr. Cecil A. Morrow, Viola, was honored by members of the Richland County Medical Society on March 9, when they met for a farewell dinner at the Park Hotel in Richland Center. Doctor Morrow left his practice on March 20 to take up the study of allergy at Cleveland before beginning a specialized practice at Kenosha. Mr. C. H. Crownhart, executive secretary of the State Medical Society, acted as toastmaster. Following the dinner, a discussion of cirrhosis of the liver was given by Drs. George Schwei and Robert Straughn, of Jackson Clinic, Madison. Doctor Schwei presented the surgical aspects of treatment, and Doctor Straughn discussed the medical aspects.

Trempealeau—Jackson—Buffalo

Senator R. M. Schlabach, La Crosse, addressed the meeting of the Trempealeau– Jackson–Buffalo County Medical Society at the city hall in Galesville on March 18. His subject was "The Law of Malpractice.

Waukesha

Meeting at the Avalon Hotel in Waukesha on March 3, members of the Waukesha County Medical Society heard a talk on the "Newer Aspects in Treatment of Diabetes Mellitus" by *Dr. Edgar S. Gordon*, Madison. Doctor Gordon is associate professor of medicine at the University of Wisconsin Medical School.

Walworth

Lakelawn Hotel at Delavan was chosen as the meeting place for members of the Walworth County Medical Society and their wives on March 11. Following a dinner, *Dr. Bruno Peters* of Milwaukee discussed "Treatment of Nephritis" and a business session was held.

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in pregnancy

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—*Bockus, H. L.: Gastro-Enterology, Philadelphia, W. B. Saunders Company, 1946, vol. 3, p. 999.*

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Washington—Ozaukee

A dinner with members of the auxiliary preceded the business session of the Washington–Ozaukee County Medical Society in Port Washington on February 26. A committee was appointed to arrange for the spring clinic to be held at West Bend in April.

The Schwartz in Hartford was the meeting place for the Society on March 18, when members heard Dr. M. C. F. Lindert of Milwaukee speak. Doctor Lindert chose "Jaundice" as his subject for discussion.

Winnebago

Members of the Winnebago County Medical Society met on March 11 at the home of *Dr. W. N. Linn* to commemorate the doctor's forty years of practice in the city of Oshkosh. Movies were shown on intravenous pentothal sodium anesthesia and curare.

Wood

Members of the Wood County Medical Society gathered at the Hotel Charles in Marshfield on March 11 to hear talks by two members of their group. "The Low Sodium Diet: Its Preparation and Use" was discussed by Dr. F. J. Gouze, Marshfield, and a talk on "Caudal Anesthesia" was presented by *Dr. R. F. Lewis*, also of Marshfield.

Officers who will head the organization this year are *Drs. C. A. Vedder*, Marshfield, president; *Otto Backus, Nekoosa*, vice-president; *R. W. Mason*, Marshfield, secretary; *Roger E. Garrison*, Wisconsin Rapids, delegate; and *F. X. Pomainville*, Wisconsin Rapids, alternate delegate.

News Items and Personals

E. H. Brooks Celebrates Fiftieth Anniversary of Medical Practice

Observing his fiftieth anniversary in the practice of medicine, *Dr. Everett H. Brooks*, Appleton, was honored by the Outagamie County Medical Society at its March meeting at the Conway Hotel. About eighty friends were present to congratulate the doctor, who has been in the medical field in Appleton since August 1902.

A native of Bloomington, Doctor Brooks was educated at Hahnemann Medical College, Chicago, graduating in 1897. After his internship at Hahnemann Hospital, he was made assistant medical director of Indiana Medical Springs in Attica, Indiana. In 1900 he went to Europe, where he studied in Vienna and London, specializing in diseases of the eye, ear, nose, and throat. On his return he located in Appleton, where he has practiced since. At the age of 75, the doctor has no plans for retirement.

T. J. LaHam Succeeds C. U. Senn as Chief of Ripon Hospital Staff

Dr. J. T. LaHam on March 2 was named chairman of the staff of Ripon Municipal Hospital, succeeding the late *Dr. C. U. Senn*. *Dr. William Schuler* was elected secretary.

Dr. J. H. Karsten Resigns as Plant Physician

After serving for twenty-two years as plant physician at the John Deere–Van Brunt Manufacturing Company in Beaver Dam, *Dr. John H. Karsten*, Horicon, has resigned that position because of the stress of private practice. *Dr. E. H. Federman*, Horicon, is serving temporarily as industrial physician in his place.

G. A. Fostvedt Named to Barron County Position

The Barron County Health Committee has announced the appointment of *Dr. G. A. Fostvedt* of Barron as medical advisor. Doctor Fostvedt replaces *Dr. R. W. Adams* of Chetek, who served in that capacity for four years.

J. A. Killins Certified by Specialist Board

Dr. J. A. Killins, Green Bay, has been certified by the American Board of Surgery. Doctor Killins is associated with the Green Bay Clinic.

R. L. Krohn Reappointed County Chairman of Cancer Drive

Dr. Robert L. Krohn, Black River Falls, has been reappointed chairman of the campaign for funds in Jackson County as part of the drive by the Wisconsin Division of the American Cancer Society. The appointment was made by Mr. Oscar T. Jacobsen, Racine, state campaign chairman.

J. D. Walsh Opens Cudahy Office

Continuing his already established practice of ophthalmology in Wauwatosa, *Dr. James D. Walsh* has also recently opened an office in Cudahy, where he will see patients by appointment. The doctor, a graduate of the University of Wisconsin Medical School, studied ophthalmology at the University of Pennsylvania School of Medicine.

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A. W. Axley Enters Practice in Montana Clinic

Dr. A. W. Axley, formerly of Neenah, left that city on February 26 to become associated with the staff of Havre Medical Clinic, Havre, Montana. A specialist in internal medicine, Doctor Axley was chairman of the Neenah Health Council during his stay in that city.

C. A. Morrow Leaves Viola Practice to Specialize

Dr. Cecil A. Morrow, who has been in practice at Viola for fifteen years, left that community on March 20 to take up the study of allergy at Cleveland, Ohio. Following the completion of his course, he will enter the practice of allergy in Kenosha. The doctor, a graduate of Rush Medical College, Chicago, came to Viola after completing his internship at St. Mary's Hospital, Madison.

T. D. Elbe Occupies New Office Building

The construction of a new office building for *Dr. T. D. Elbe*, Thiensville, has recently been completed, and the doctor is now receiving patients there. The building is of modern design and includes consultation, waiting, x-ray, utility, and examining rooms.

V. S. Falk Begins Practice in Edgerton

Dr. Victor S. Falk, Jr., on January 1 joined the Shearer Brothers and Sumner Clinic at Edgerton. Doctor Falk was chief resident in surgery at the Augustana Hospital, Chicago, prior to coming to Edgerton.

Captain E. B. Keck Ordered to Mediterranean Area

Captain Everett B. Keck (MC) has been ordered to the staff of the commander, Naval Forces, Mediterranean, as fleet surgeon. He has served as chief of surgery at the United States Naval Hospital, Brooklyn, since March 1946. Captain Keck practiced in Madison prior to his entrance into military service.

A. A. Cantwell Named Head of Shawano YMCA

A. A. CANTWELL

Dr. A. A. Cantwell, Shawano, was recently elected president of the YMCA in that city. Doctor Cantwell has been serving in that capacity since last March, when he was chosen to fill a vacancy caused by the death of the president at that time.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

J. R. Schroder Completes Course at Minneapolis

Dr. John R. Schroder recently returned to his medical work in Janesville after completing a continuation course in pediatrics at the University of Minnesota Medical School. Doctor Schroder is associated with the Pember–Nuzum Clinic in Janesville.

Dr. Vincent Koch Speaks to Nurse Group

Dr. Vincent Koch, Janesville, was a guest speaker at the meeting of the Second District, Wisconsin State Nurses Association, in that city on March 11. His subject was "Rheumatic Fever." Doctor Koch is a former president of the Wisconsin Heart Association.

SOCIETY PROCEEDINGS

Dane

Two aspects of "BAL Therapy in Poisoning with Heavy Metals" were discussed at a meeting of the Dane County Medical Society at the Madison Club on March 9. *Dr. Norman Clausen*, Oregon, presented the experimental aspects, and *Dr. J. LeRoy Sims*, Madison discussed the clinical aspects.

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MEDICAL STAFF

William L. Herner, M. D., Medical Director
Frank W. Mackoy, M. D. — George W. Dean, M. D.
J. Frampton Wyman, M. D. — Paul J. Matelcka, M. D.
Hubert H. Blanchard, M. D. — Owen C. Clark, M. D.
John E. Leach, M. D.

THIRD DISTRICT PHARMACISTS

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TWELFTH DISTRICT NEWS

Marquette Medical Alumni Association Names New Officers

At a recent ballot election of the Marquette Medical Alumni Association, *Dr. Joseph Gramling* was reelected a director and *Dr. J. D. Wilkinson* of Oconomowoc was elected to the directorship formerly held by *Dr. Robert Fitzgerald. Dr. M. J. Fox* was named president, and *Dr. J. D. Wilkinson,* vice-president. Dr. Dexter White was reelected treasurer.

Date Set For Annual Marquette Clinics

The annual Marquette clinics will be held May 13, and a banquet will be held at the Milwaukee Athletic Club.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

Following a dinner at the University Club of Milwaukee, members of the Milwaukee Academy of Medicine on March 16 heard a talk on "Prefrontal Lobotomy" by Dr. Paul C. Bucy, Chicago. The doctor is professor of neurology and neurologic surgery at the University of Illinois College of Medicine.

Milwaukee Oto-Ophthalmic Society

Guest speaker at the March meeting of the Milwaukee Oto–Ophthalmic Society was Dr. Kenneth M. Day of Pittsburgh, who talked on "Ménière's Syndrome" and commented on fenestration surgery, illustrating his subject with movies and slides. The group met at the Milwaukee Athletic Club on March 23. "Tumors of Ciliary Body," with a report of a case, was the title of a paper presented by *Dr. M. Kadin* of Racine.

Five departments of Mount Sinai Hospital combined to present the program at the meeting on February 24 at the Milwaukee Athletic Club. Following introductory remarks by *Dr. M. S. Fox,* a case report of fenestration surgery was presented by *Dr. Gerhard Straus.* "Encephalitis and Chiasmitis" was the subject of discussion by *Drs. E. E. Grossman, Norbert Enzer,* and *J. Mufson.* The scientific session was concluded by reports of cases of "Ocular and Nasal Findings of Lesions of the Optic Foramen" from the various participating departments. *Dr. S. S. Blankstein* reported from the department of ophthalmology; *Dr. M. S. Fox* from the department of otolaryngology; Dr. M. Moel from the radiology department; *Dr. Norbert Enzer* from the pathology department; and *Dr. J. Mufson* from the department of neurosurgery.

Milwaukee Neuro-Psychiatric Society

A symposium on "Prefrontal Lobotomy" was presented at the meeting of the Milwaukee Neuro–Psychiatric Society held March 17 at the University Club. Speakers who participated were *Drs. Theodore C. Erickson,* Madison, *David Cleveland,* Milwaukee, *Joseph Kindwall,* Wauwatosa, and *R. A. Jefferson,* Milwaukee.

SOCIETY RECORDS

New Members

Gerald P. Fitzgerald, 508 West Milwaukee Street, Janesville.

John W. Frye, St. Joseph's Hospital, Marshfield.

Harold Guzzo, Washburn.

Oliver M. Hitch, 407 Northern Building, Green Bay.

George J. Hugo, Kaukauna.

Leigh W. Keller, Rock Springs.

Bernard J. Mansheim, St. Francis Hospital, La Crosse.

Floyd W. Ernst, 322 Exchange Building, La Crosse.

A. R. Zintek, 1 West Wilson Street, Madison.

Paul J. Reinsch, Wisconsin General Hospital, Madison.

Darwin D. Waters, Wisconsin General Hospital, Madison.

Carl A. Stolberg, Wisconsin General Hospital, Madison.

Joseph E. Murphy, Milwaukee County Hospital Wauwatosa.

Louis W. Sennett, 3030 North Forty-fifth Street, Milwaukee.

John R. Evrard, 7006 West Greenfield Avenue, West Allis.

Jack E. Gruender, 231 West Michigan Street, Milwaukee.

David C. Mountain, 720 North Jefferson Street, Milwaukee.

Melvin A. Cassel, Veterans Administration, Wood.

Hobart E. Wallace, Milwaukee Children's Hospital, Milwaukee.

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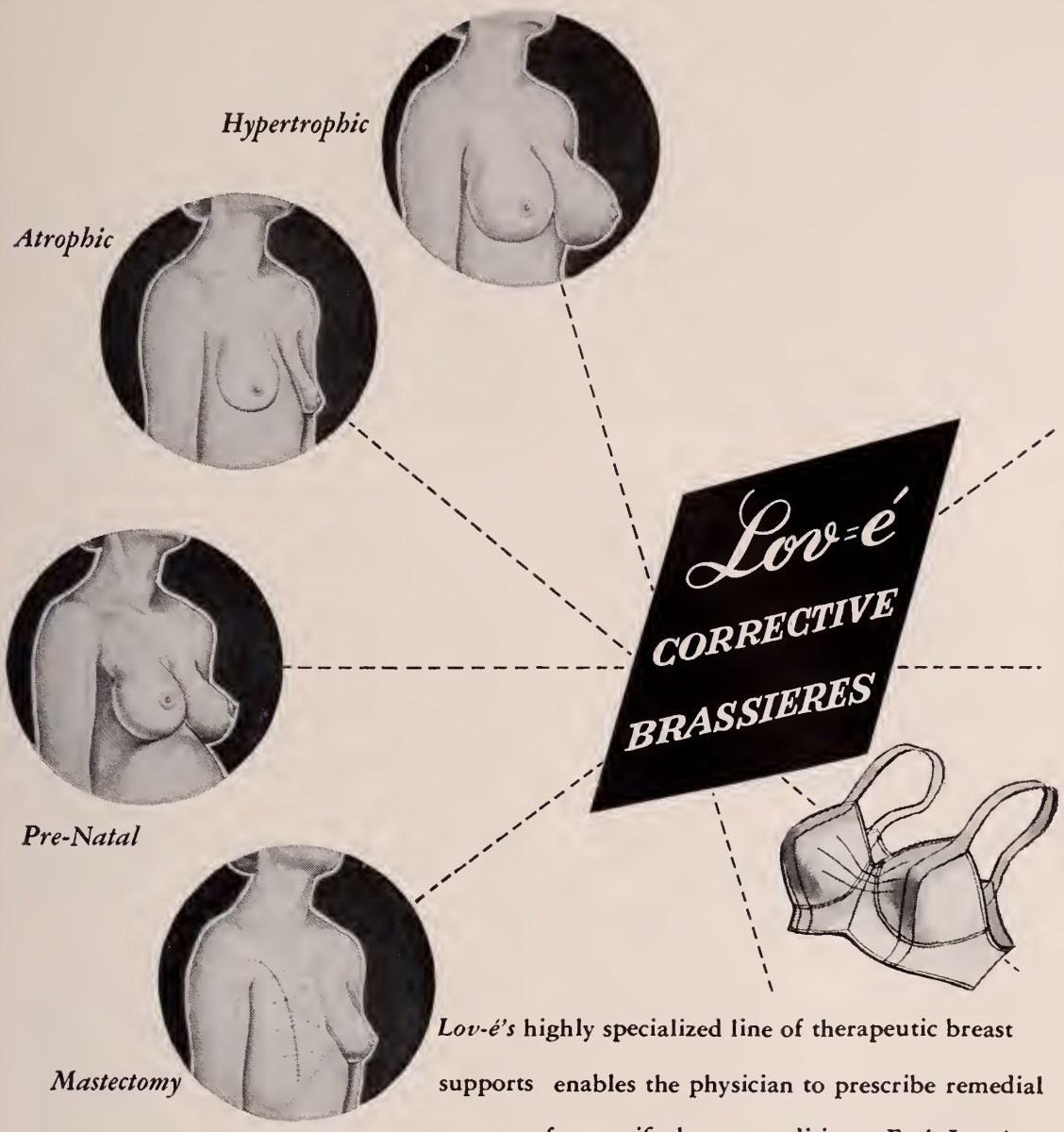

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Joseph B. Cushman, Milwaukee County General Hospital, Wauwatosa.

Alvin M. Kurzon, 4729 A South Packard Avenue, Cudahy.

Jacob N. Shanberge, 238 West Wisconsin Avenue, Milwaukee.

Daniel E. Hackbarth, Veterans Administration, Wood.

Frederick L. Evans, 7608 West State Street, Wauwatosa.

George D. Schmitt, 2123 West Wells Street, Milwaukee.

Stewart L. Griggs, Milwaukee Children's Hospital, Milwaukee.

John East, St. Joseph's Hospital, Milwaukee.

James C. Mankey, Milwaukee County General Hospital, Wauwatosa.

David H. Gatherum, Veterans Administration, Wood.

Walter R. Schatz, 2043 Douglas Avenue, Racine.

Henry W. Harris, Gundersen Clinic, La Crosse.

John T. Skemp, 312 State Street, La Crosse.

William T. Russell, Waterloo.

Frederick Rosenfeld, Phelps.

Benjamin F. Palmer, Three Lakes.

John B. Miale, Marshfield Clinic, Marshfield.

George M. Simon, St. Nazianz.

Maurice E. Rowe, Madison General Hospital, Madison.

Anton A. Tratar, College Apartments G-3, Rochester, Minnesota.

Lou R. Schmidt, Rivoli Building, La Crosse.

Cecil C. H. Cullander, Great Lakes Naval Hospital, Great Lakes, Illinois.

Robert C. Jackson, Veterans Hospital, San Fernando, California.

Robert C. Puestow, Veterans Administration, Mendota.

James J. Batty, Veterans Administration Hospital, Muskogee, Oklahoma.

Changes in Address

B. J. Haines, Helena, Montana, to 1804 West Congress Street, Chicago, Illinois.

A. W. Axley, Neenah, to Havre Medical Clinic, Havre, Montana.

H. M. Levin, Darien, to Delavan.

J. R. Hurley, Wood, to 324 East Wisconsin Avenue, Milwaukee.

O. F. Dierker, Oteen, North Carolina, to Watertown.

R. J. Kinney, Madison, to 3102 North Central Avenue, Topeka, Kansas.

L. E. Gallett, Chicago, to 415 South Seventh Street, Springfield, Illinois.

W. S. Marshall, Mobile, Alabama, to Sayton Building, Citronelle, Alabama.

F. J. Flanagan, Algoma, to Little Chute.

M. J. Murphy, Wauwatosa, to Stevens Clinic Hospital, Welch, West Virginia.

F. A. Grueson, Fort Atkinson, to 812 South Ninth Street, Watertown.

DEATHS

Dr. John F. Stein, practicing physician at Oshkosh for twenty-five years, died at a hospital in that city on March 15. He was 66 years old.

Born in Hastings, Minnesota, on July 18, 1881, Doctor Stein received his medical education at Milwaukee Medical College, now Marquette University School of Medicine. Following graduation in 1905, he practiced at Dennison, Texas, for a period of years before moving to Oshkosh. During his practice at Oshkosh, he was on the staff of Mercy Hospital and for twenty-one years was Oshkosh aerie physician for the Fraternal Order of Eagles.

During World War I the doctor served overseas, being stationed with the aviation medical corps at a base hospital in France. Following his discharge in 1920 he served in the Reserve Corps and received a captain's commission.

He was a member of the American Legion and of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his wife and a daughter and a son from a former marriage.

Dr. Julia Woodzicka, practitioner at Royalton for forty-eight years, died at a Waupaca hospital on February 22, the day before her eighty-third birthday. She had retired from practice several years ago.

A native of Royalton, Doctor Woodzicka was born there on February 23, 1865. She received her degree in medicine from Northwestern University Medical School in 1899 and for a time thereafter had charge of the Kirkland Free Dispensary in Chicago. After practicing in Sheboygan for a time, she returned to Royalton to open an office. Following a period of travel she lived in New London for a number of years before settling permanently in Royalton.

There are no immediate survivors.

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Dear Doctor:

On behalf of the Council on Scientific Work, it is my privilege and pleasure to invite you to participate in one of the three Postgraduate Teaching Clinics described in this brochure.

These clinics are offered members of the State Medical Society of Wisconsin as a means of keeping practicing physicians abreast with the latest medical information in the fields of professional activity which are of greatest concern to Wisconsin physicians.

We feel honored to have such distinguished physicians as Doctors Jensen, Thompson, Harris, and Schaefer serve as teachers for these meetings.

Your attendance and active participation are urgently requested.

Sincerely yours,

C. F. Midelfort, M. D., Chairman
Council on Scientific Work

The Teaching Staff

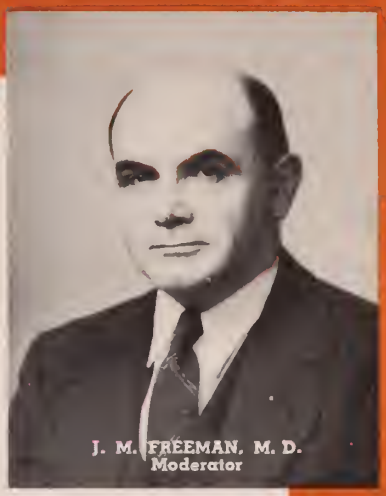
JOHN W. HARRIS, M. D., is well known to the majority of Wisconsin physicians, as he has participated in the educational programs of the State Medical Society for many years. He is a graduate of Johns Hopkins University School of Medicine, Baltimore, class of 1916. Following his graduation and until 1928, he served as a teacher of obstetrics at Johns Hopkins, leaving to become professor of obstetrics and gynecology at the University of Wisconsin Medical School, which post he now holds. Doctor Harris also serves as a member of the Committee on Maternal and Child Welfare of the State Medical Society.

REYNOLD A. JENSEN, M. D., associate professor of pediatrics at the University of Minnesota Medical School, had much of his early education and premedical training in Wisconsin, so his participation in the clinics is in the nature of a "homecoming." He started his professional career as a teacher, but then entered Y.M.C.A. work following graduation from River Falls State Teachers College in 1925. In 1929 he entered the University of Minnesota Medical School, graduating in 1934. Following postgraduate study at the University of Minnesota Hospital, three years at Rochester, New York, and a year in Philadelphia, he returned to Minnesota to become assistant director of the Psychiatric Clinic for Children. He now is responsible for the child psychiatric program at the University of Minnesota.

ARTHUR A. SCHAEFER, M. D., assistant clinical professor of surgery at Marquette University School of Medicine, is a native of Wisconsin and a graduate of Harvard Medical School, class of 1928. His special interest is in the field of pediatric surgery, with which specialty he is identified as a staff member of Milwaukee Children's Hospital. Doctor Schaefer has appeared before many medical groups in Wisconsin, and in 1944 made a significant contribution on the industrial health clinics held in various parts of the state, speaking on the newer methods in the treatment of burns.

WILLARD O. THOMPSON, M. D., nationally known physician of internal medicine, with special interest in the field of endocrinology, is a Canadian by birth. He secured his medical education at Harvard Medical School, graduating in 1923. Following graduation, he did a great deal of postgraduate work at Harvard, also serving as director of the metabolism laboratory at Massachusetts General Hospital, Boston. Since 1929 he has been associated with the teaching staff of the University of Illinois College of Medicine, Chicago, holding the position of clinical professor of medicine at the present time. During the war he took an active part in developing the graduate medical meetings presented under the joint sponsorship of the American Medical Association, the American College of Physicians and the American College of Surgeons. He has also taken an active role in the editorial affairs of the *Journal of Clinical Endocrinology* and in the work of the National Board of Medical Examiners.

The Teaching Program


J. M. FREEMAN, M. D.
Moderator

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- WAUSAU—Hotel Wausau
- MANITOWOC—Hotel Manitowoc

9:30–10:00 a.m.: Registration

10:00–10:40 a.m.: "Problems in Pediatric Surgery": Arthur A. Schaefer, M. D., assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee.

10:40–11:20 a.m.: "Androgen and Estrogen Therapy": Willard O. Thompson, M. D., clinical professor of medicine, University of Illinois College of Medicine, Chicago.

11:20–12:00 a.m.: "Bleeding in Late Pregnancy—Causes and Treatment": John W. Harris, M. D., professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison.

12:00– 1:00 p.m.: Buffet Luncheon

1:00– 1:40 p.m.: "The Physician and Preventive Psychiatry": Reynold A. Jensen, M. D., associate professor of pediatrics and psychiatry, University of Minnesota Medical School, Minneapolis. (The services of Doctor Jensen have been made available in part through the Division of Mental Health of the State Board of Health.)

1:40– 2:00 p.m.: Clinical case study in pediatric surgery: Doctor Schaefer

2:00– 2:20 p.m.: "Present Status of Treatment of Toxic Goiter": Doctor Thompson

2:20– 2:40 p.m.: Recess

2:40– 3:00 p.m.: "Recent Trends in Clinical Obstetrics": Doctor Harris

3:00– 3:30 p.m.: "Physical Complaints Without Organic Basis": Doctor Jensen

3:30– 5:00 p.m.: PATHOLOGICAL CONFERENCE

Through the cooperation of the local medical society, arrangements will be made for the presentation of a clinical pathological conference. All members of the teaching faculty and a representative of the local county medical society in charge of this feature of the clinic will be participants. The Council on Scientific Work has requested that this be an added feature of the clinics, and it is felt that physicians attending the meetings will be especially interested in this feature of the program.

Reservations Please!

Hotels require advance reservations, so kindly inform us if you will participate in this teaching program.

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THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

February 26, 1948

Dear Sir:

Thank you for your letter of February 10 and for the copy of the 1948 Medical Blue Book.

This book should be invaluable to every Wisconsin physician, particularly the section on law. It answers most of the questions that arise in the work of the physician, and thereby renders a great service to the medical profession.

The section on fee splitting on page 59 might well guide other states in similar problems. I have suggested the laws make barter or trade in the sick a felony; then conviction of the physician on a charge of felony would permit removal of his license.

The one great lack which I find in your Blue Book is a detailed subject index. It might be difficult to prepare this, but it would add tremendously to the use of the book.

With best wishes,

Sincerely yours,

(Signed) MORRIS FISHBEIN

AMERICAN MEDICAL ASSOCIATION

Office of the President-Elect

March 17, 1948

Dear Sir:

I think that your Blue Book of 1948 reflects very favorably on *The Wisconsin Medical Journal.* It is particularly thoughtful and helpful to give this broadly inclusive number of the *Journal* to the medical students of your Wisconsin medical schools.

I do not have any suggestions as to new material for your 1949 edition. However, the rapidly progressing position of leadership by medical organizations in social problems in which medicine is rightly interested will, no doubt, point into new areas. Physicians must lead in providing the best medical care or be forced into positions in which medical care will be subordinate to political machinery.

I am sure that material will develop of comparable importance to that which you have included in these excellent Blue Book issues. I'll try to keep this in mind and will be glad to suggest anything that comes to me.

Sincerely yours,

(Signed) R. L. SENSENICH, M. D.

AMERICAN MEDICAL ASSOCIATION

March 2, 1948

Dear Sir:

I am indeed sorry that I am so late in answering your letter of February 10, but have been out of town so much during the month of February that I just last evening had an opportunity of reviewing your 1948 Blue Book issue of the Wisconsin Medical Journal.

I really think that this is an outstanding job. Law is something that very few doctors take sufficient time to be properly informed on and bringing it out as you have in your Blue Book, "An Introduction to Law," certainly brings it to the foreground and brings it before the profession so that there is no excuse for them not to be properly informed. I think that sending complimentary issues to the Junior and Senior medical students is indeed very commendable.

I have been much interested in your Journal for a number of years and feel that you are doing one of the best jobs in the publication of the Journal of any state in the Union. In fact, you have an outstanding medical organization in Wisconsin of which we are all proud. It would indeed be difficult for me to offer any suggestions for the improvement of the Journal as it is now tops.

Sincerely yours,

(Signed) E. L. HENDERSON

Chairman, Board of Trustees

AMERICAN MEDICAL ASSOCIATION

March 2, 1948

Dear Sir: Thank you for sending me a copy of the *Wisconsin Medical Journal* Blue Book and your good letter of February 10.

Dr. McIntosh's article is rather illuminating, and your foresight in sending this issue to medical students of Wisconsin schools is to be highly complimented.

I do not feel equal to your invitation to suggest improvements on such a well selected and expert presentation of useful material. That you know your audience well and know how to satisfy it, is quite evident. You give it splendid value in your excellent journal.

Sincerely yours,

(Signed) TOM GARDINER

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SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

A dinner meeting of the Auxiliary to the Columbia–Marquette–Adams County Medical Society was held February 10 at St. Savior's Hospital at Portage.

Mrs. Clement Chelie, president of the group, gave a very enthusiastic report of the State Auxiliary meeting. Mrs. James Macgregor of Portage gave a fine report on the Blue Cross and Physician's Service plan and on the various plans for prepaid medicine. A review of Bernard De Voto's article on the American Medical Association convention in Atlantic City, New Jersey, was given by Mrs. J. P. Harkins. There were sixteen members at the meeting.

Dane

A dessert luncheon meeting was held by the Auxiliary to the Dane County Medical Society on March 8 at the home of Mrs. H. Lewis Greene.

After the business meeting, a talk on flower arrangements was given by Mrs. Robert O. McLean.

Fond du Lac

Mrs. H. R. Sharp was hostess at the February meeting of the Auxiliary to the Fond du Lac County. After the dinner, an address was given by Mr. Ralph Weber, executive director of the Wisconsin Physician's Service. The subject of his address was "The Voluntary Prepayment Medical Insurance Plan."

Dr. K. K. Borsack entertained the group with slides and a lecture depicting highlights in the life of Abraham Lincoln.

Kenosha

The February meeting of the Auxiliary to the Kenosha County Medical Society was held at the Elks Club. The Auxiliary was honored by the presence of Mrs. A. W. Hammond, State Auxiliary president.

Mrs. Hammond told of the work being done by the medical auxiliaries in the state to help improve conditions in the state hospitals for the mentally ill. She also stressed the necessity of the general public being kept informed regarding legislative actions, both state and national, concerning health measures so vital to this country.

La Crosse

On February 25, a tea for the Auxiliary to the La Crosse County Medical Society was held at the home of Mrs. George B. Ridout, president.

Dr. J. Burris Perrin of the La Crosse Health Department gave an interesting talk on long range plans of the department. He stressed improvements of tuberculosis diagnosis by the addition of an x-ray machine provided by the State Board of Health, increases in the service of the dental clinic, expansion of the health department personnel, and development of the La Crosse sanitation system. The department is also interested in the development of the child guidance clinic and the cancer information service started recently in the city.

Milwaukee

One hundred members attended the February meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County held at the Knickerbocker Hotel on February 13.

The Study Group met at 10:30 a.m. for a discussion of the Wagner–Murray–Dingell Bill. Luncheon was served at 12:30.

The Reverend Henry Gerecke, chaplain of the United States Disciplinary Barracks, was the guest speaker on the subject "My Personal Observations at the Nuremberg Trial."

A short business meeting followed.

Sheboygan

A 1 o'clock luncheon for the Auxiliary to the Sheboygan County Medical Society was held on February 4 at Prange's Shore Room. Mrs. Henry Winsauer, a member of the group, who has come to America from Alexandria, Egypt, spoke on her native land.

Washington—Ozaukee

A joint dinner meeting with the Washington-Ozaukee county Medical Society was held on January 22.

Following the dinner served at St. Joseph's Hospital, separate meetings were held.

At a business meeting, Mrs. R. G. Edwards was nominated president-elect of the Auxiliary.

The February meeting was held at Port Washington. The program consisted of non-scientific movies provided for the doctors and their wives. At the business meeting, Mrs. E. J. Bernhardt gave a report on the state mid-winter conference meeting held in Milwaukee.

Winnebago

The February meeting of the Auxiliary to the Winnebago County Medical Society was held at the home of Mrs. William Hildebrand at Menasha.

At the business meeting, presided over by Mrs. Bitter, Mrs. F. C. Senn of Oshkosh, one of the oldest members of the Auxiliary, was made an honorary member of the organization. Reports on the recent state board meetings in Milwaukee were made by Mrs. R. H. Bitter and Mrs. Henry Kleinschidt.

NOTES ON CLINICAL PATHOLOGY

(Continued from page 406)

10. Watson, C. J., and Rappaport, E. M.: A comparison of the results obtained with the Hanger cephalin–cholesterol flocculation test and the Maclagan thymol turbidity test in patients with liver disease, J. Lab. & Clin. Med. 30:983–991 (Dec.) 1945.

11. Neefe, J. R.: Results of hepatic tests in chronic hepatitis without jaundice; correlation with clinical course and liver biopsy findings, Gastroenterology 7:1–19 (July) 1946.

12. Neefe, J. R., and Reinhold, J. G.: Laboratory aids in the diagnosis and management of infectious (epidemic) hepatitis; analysis of results obtained by studies of 34 volunteers during the early and convalescent stages of induced hepatitis, Gastroenterology 7:393–413 (Oct.) 1946.

13. Havens, W. P., Jr., and Marck, R. E.: A comparison of the cephalin–cholesterol flocculation and thymol turbidity tests in patients with experimentally induced infectious hepatitis, J. Clin. Investigation 25:816–821 (Nov.) 1946.

14. Kingsbury, F. B., Clark, C. P., Williams, G., and Post, A. L.: The rapid determination of albumin in urine, J. Lab. & Clin. Med. 11:981–989 (July) 1926.

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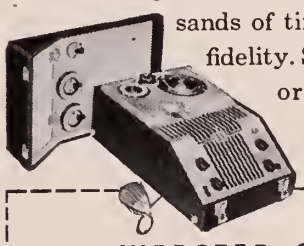

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Internal Medicine in General Practice. By Robert Pratt McCombs, B. S., M. D., F. A. C. P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Second Edition, Illustrated. Pp. 741. Philadelphia and London: W. B. Saunders Company, 1947. Price $8.00.

This second edition of Doctor McCombs' text on "Internal Medicine in General Practice" is much more abreast of current developments than is usually to be expected in a text of this size. A good deal of new material and, in particular, entirely new chapters on psychiatric disorders and vascular disturbances of the extremities have been introduced. Discussions are clearly phrased and easily read. Of particular value to the individual in practice is the routine specification of exact dosages and therapeutic technics as well as the employment of tabular summarization in the case of such differential problems as chest pains of noncardiac origin, causes of cyanosis, hemorrhagic diseases, and so on. Much information not present in the usual textbook of medicine is included, and those who customarily employ one of the other standard texts might, therefore, find this of value as a supplementary reference. The reviewer was particularly sympathetic with the author's incidental comments from time to time in regard to various widespread customs in the practice of medicine and would particularly like to recommend the brief essay on diagnosis which appears on the four introductory pages of the text.

The illustrations are of excellent quality and well chosen. If there is to be a single major criticism of the book it would be directed at its brevity, because of which the discussion of many conditions serves only to tantalize rather than to inform the reader. This brevity is so consistent throughout that the text cannot be recommended as a primary reference for the individual in practice in spite of its many excellent qualities.—J. L. S.

The Psychology of the Behavior Disorders; A Biosocial Interpretation. By Norman Cameron. Houghton Mifflin Company, 1947.

Doctor Cameron's recently published book, entitled "The Psychology of the Behavior Disorders," is one of the most significant books to appear in the field of psychology and psychiatry in recent years. It is the first presentation this reviewer has seen to date of a new and stimulating view of human adjustment and the behavior disorders. It deals in the field of human reactions and unites what we observe in clinical psychiatry with what we have learned in sociology and psychology into a consistently objective and compelling understanding of human behavior. With this view, the various researches dealing with human beings and their problems—clinical medicine and psychiatry, psychoanalysis, experimental and clinical psychology, and sociology—all these disciplines and points of view seem more as different points of attack upon the same problem, each complementing the other and each contributing something unique to a new total view. Here, then, is a frame of reference with which a worker in any of these fields may see his work in greater perspective and find new ideas for further researches.

It is not within the scope of a short review to mention more than a few of the high points and the general scheme of the book. Doctor Cameron subtitles his book, "A Biosocial Interpretation." By biosocial, he means to consider human beings always in terms of their environmental situation, always in terms of the social contexts in which they live, the stresses and strains to which they are subjected. The first half of the book is devoted to a discussion of the psychologic development of a person and to the various technics of adjustment he uses in his everyday life. Doctor Cameron in this section, deals with things which are observable by other people and consistently refuses to explain observable phenomena in terms of hereditary predisposition, constitutional abnormality, or unconscious but dynamic forces oper-

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ating in an hypothetic id. His thesis is that our methods of handling frustrating situations, our technics for relieving the anxieties produced by conflict, our attitudes towards others, our ability to determine and attain what we seek in life—in a word, our behavior—is an expression of learning, just as a good game of golf represents learning. Thus, it is through learning that we come to be able to take various points of view successively, to change our perspectives rapidly with the situation. This learned capacity, Doctor Cameron calls role-taking, and he feels that the efficiency and ease with which a person can change and adopt new roles determines to a large extent his ability to adjust adequately. In any given role, a person is aware of certain aspects of the environment and the human situation while he is correspondingly unaware of many other aspects of the same environment. This he terms reaction-sensitivity. The person who is without the capacity for changing roles, who is limited to one or a few attitudes and perspectives, is capable of being reaction-sensitive, therefore, to only a limited number of the environmental factors and he is unable to test his experiences from different perspectives and to share them adequately with others. In such a person, the stage is set for the development of a behavior disorder.

Doctor Cameron continues in this first section of his book to a discussion of the various general technics of adjustment. These he divides into the defense and the escape technics and discusses several varieties of each. Among the escape technics is repression. He does not consider repression a dynamic and mysterious process, but looks upon it as the observable phenomenon which occurs when a person fails to respond in his usual way in the presence of a previously adequate stimulus. Repression is viewed as simply exclusion and is compared to the organization involved in the development of a smooth, skilled act, where what is excluded from the act is as important as what is included. Repression, then, is a determined act requiring more or less effort on the part of the individual. In the repression of a conflict, one of the opposing tendencies comes to be just dropped out of the person's current behavior repertory. This concept of repression is a very valuable one and goes a long way toward the better understanding of behavior disorders.

In the second section of the book, Doctor Cameron considers in detail the various general types of behavior disorders—hypochondriac disorders, fatigue syndromes, anxiety states, compulsive disorders, hysterical disorders, paranoid and schizophrenic disorders, and the manic and depressive disorders.

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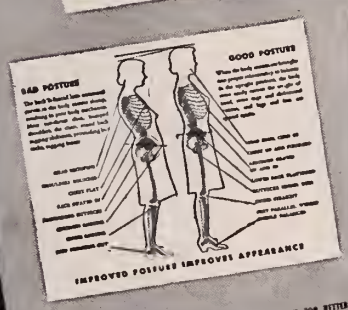

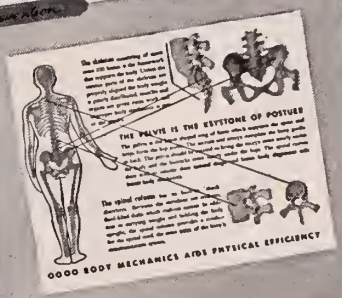

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With each type, he first discusses and describes rather briefly, with a few case histories, the symptomatology and then in two succeeding sections he asks and answers the following questions: "From what characteristics of normal human behavior does this disorder of behavior arise?" and "What determinants are there which seem to favor the development of this particular disorder in those individuals who come to demonstrate it?" Space does not here permit a fuller discussion of this section of the book. Suffice it to say that Doctor Cameron never falters from understanding patients in terms of their whole development, their experience and their social milieu. The most stimulating and rewarding sections to this reviewer were the sections on the hysterical and schizophrenic disorders.

It is the opinion of this reviewer that this book by Doctor Cameron, who is both a psychologist and a psychiatrist, is the most exciting and refreshingly new book he has seen in the field of the behavior disorders. Its view is at once scholarly and completely understandable, and at the same time, it possesses a profound depth of understanding and respect for people and their problems. He urgently recommends the book to the attention of all the staff.—O. O.

Unipolar Lead Electrocardiography; Including Standard Leads, Unipolar Extremity Leads and Multiple Unipolar Precordial Leads. By Emanuel Goldberger, B. S., M. D., Adjunct Physician, Montefiore Hospital, New York; Cardiographer and Associate Physician, Lincoln Hospital, New York; Diplomate of the American Board of Internal Medicine; Clinical Lecturer in Medicine, Columbia University, Faculty of Medicine. Pp. 182, with 88 illustrations. Philadelphia: Lea & Febiger, 1947. Price $4.00.

This work is based essentially on the use of an active or exploring electrode in conjunction with an indifferent electrode which does not change potential as a result of cardiac activity. The indifferent lead is obtained by combining leads from the extremities, the two arms and the left leg, through equal resistances to a common terminal. This forms a closed network, and according to Kirchhoff's law the flow of current through it algebraically sums to zero. The potentials recorded are thus predominantly from the exploring electrode. Unipolar electrocardiograms are taken from various positions on the chest and comparisons made with the standard bipolar extremity leads. Six unipolar precordial leads, three unipolar extremity leads, and three standard bipolar extremity leads are routinely taken. The unipolar leads in normal subjects are described and the patterns related to potential differences in the heart and to the position of the heart in relation to the lead. Abnormal electrocardiograph patterns are then described in detail in the various types of cardiac disease. Unipolar leads are found to have distinct advantages over bipolar leads in the diagnosis of certain clinical cardiopathies. The method for taking the unipolar electrocardiograms and their interpretation are clearly described.—J. A. E. E.

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Practical X-Ray Treatment. By Arthur W. Erskine, M. D. Third Edition, Revised and Enlarged. Pp. 155, with 22 illustrations. St. Paul and Minneapolis: The Bruce Publishing Company, 1947.

The purpose and nature of this book can best be characterized by the opening paragraph taken from the introduction to its first edition: "It has seemed to me that there is need for a small book on x-ray therapy devoted entirely to the methods of an individual in which no attempt is made to consider the opinions of various writers or to reconcile their differences. I have set down, therefore, as simple and clearly as I can, the methods used by myself, and my reasons for selecting them. No claim is made that they are the best methods. On the contrary, it is certain that many of them should be, and will be, modified and improved. They have been fairly satisfactory, however, and they at least have the advantage of being simple enough to be easily described and accurately followed."

The subject matter has been arranged under the following headings: current, apparatus, protection; measuring instruments (indirect and direct); factors affecting skin dosage; factors affecting the depth-dose percentage; standard technics; scattering and distribution—this contains 22 scattering and distribution tables; determination of the skin dose; effects of x-rays on tissue; skin diseases; infections and inflammations; nonmalignant and malignant conditions. There is also a brief, one may say philosophic, chapter dealing with the cancer problem and the radiologist.

Because of the limited space available, the presentation had of course to be brief and condensed. This is a strictly individualistic book and reflects the rich experience and critical judgment of one of our pioneer radiologists.—E. A. P.

Headache. By Louis G. Moench, M. D., Assistant Clinical Professor of Medicine, University of Utah School of Medicine; Internist, Salt Lake Clinic, Salt Lake City. Pp. 207. Chicago: The Year Book Publishers, Inc., 1947. Price $3.50.

This book is to be recommended to every physician confronted with the problem of headache, regardless of his specialty. The author begins with consideration of the pain sensitive structures and the mechanism of head pain. The work is authenticated by observations at operation on the heads of 45 patients. The text is embellished by the unstinting use of diagrams. With logic, the author develops his material first with consideration of the anatomy and physiology of headache, and then he discusses separately headaches from intracranial pathology, the neuralgias, headache of ocular origin, headache of nasal origin, pathology of the neck, headache associated with systemic disorders, the histamine headache, migraine, and the headache of emotional origin.

Fundamentally sound, lucidly presented, amply indexed, and with a comprehensive bibliography, this book, which is well printed on a good grade of paper, is highly recommended.—K. L. P.

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Coming Events

State Conference on Alcohol Studies

The State Bureau of Alcohol Studies, created recently by the state of Wisconsin, is approaching its program through education, development of treatment facilities, research into causes and treatment, and the directing of community efforts to intelligent and scientific handling of the alcoholic.

The first step in the education phase is a statewide conference to focus public attention on the problem. This conference, which is open to anyone interested in the problem, will be held April 23–24 at the Memorial Union, University of Wisconsin. The tentative program is as follows:

Friday, April 23

A. M.
9:30 Registration
10:00 "Social Aspects of Alcohol Addiction," Dr. John W. Riley, Rutgers University, New Brunswick, New Jersey

P. M.
2:00 "Alcoholism in Perspective," D. B. Rotman, M. D., director of Psychiatric Institute, Municipal Court, Chicago
3:00 "Alcoholism as a Behavior Disorder," Robert V. Seliger, M. D., chief psychiatrist of the Neuro-Psychiatric Institute of Baltimore, and executive director of the National Committee on Alcohol Hygiene, Inc., Baltimore
7:45 "Alcohol and Alcohol Addiction," E. M. Jellinek, Sc. D., director of the School of Alcohol Studies, Yale University, New Haven, Connecticut

Saturday, April 24

A. M.
9:30 "Alcoholics Anonymous"
10:30 Panel Discussion Forum: "Public Problems of Alcoholism"
Fritz Kant, M. D., professor of neuropsychiatry, University of Wisconsin Medical School
Marshall Clinard, associate professor of sociology, University of Wisconsin
Mr. Charles O'Neill, vice-president of the Association for the Prevention of Alcoholism

American Association of Anatomists

The sixty-first session of the American Association of Anatomists will be held at the University of Wisconsin Medical School April 21 through April 23. The program will begin at 10 a. m. on Wednesday with a general session in the Memorial Union theater. The afternoon will be devoted to demonstrations at Science Hall, and there will be motion pictures and a smoker in the evening. Section meetings will be held the last two days of the conference. The president of the organization, Dr. George W. Corner, Baltimore, will give his presidential address at noon on Wednesday.

Dr. W. E. Sullivan, professor of anatomy at the University of Wisconsin Medical School, is a member of the executive committee of the Association of Anatomists, and Drs. F. D. Geist, H. W. Mossman, O. A. Mortensen, M. M. Myles, A. B. Eyster, and J. H. Robbins of the university anatomy department will assist Doctor Bast and also present some of the anatomic demonstrations during these sessions. General headquarters will be at the Loraine Hotel. It is reported that this is to be the largest meeting ever to be held by the American Association of Ana-

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tomists, and the University of Wisconsin has been selected because of its excellent department of human anatomy associated with the medical school. Membership of the Association is distributed throughout the United States and Canada.

Tri-State Hospital Assembly

With its slogan, "Ideas, Ideals, Impressions, Impacts," the eighteenth annual Tri-State Hospital Assembly will be held May 3–5 at the Palmer House in Chicago, under the sponsorship of the Illinois, Indiana, Michigan, and Wisconsin Hospital Associations and sixty participating organizations and sections. Dr. Malcolm T. MacEachern, Chicago, is chairman, and Albert G. Hahn, Evansville, Indiana, is secretary.

Themes for the three morning general assemblies, which will be attended by members of all groups and sections, will be as follows: Monday, May 3, "The Personnel Factor in Hospital Management," with James A. Hamilton, Minneapolis, as moderator and Anson C. Lowitz, New York; Robert E. Neff, Indianapolis; Merton E. Knisely, Milwaukee; Leo M. Lyons, Chicago; and Norman C. Bailey, Chicago, as the speakers; Tuesday, "Increasing the Hospital Consciousness of the Community," with Dr. Dean A. Clark, New York; Dr. Kenneth B. Babcock, Detroit; Dr. Roger W. DeBusk, Evanston; and Frank F. Selfridge, Highland Park, Illinois, as the speakers and Dr. Robin C. Buerki, Philadelphia leading the discussion; Wednesday, "Long-Term Planning for Hospital Expansion and New Building," with Albert Scheidt, New Orleans; and George Bugbee, Dr. Herman Smith, and Dr. F. V. Meriwether, all of Chicago, as the speakers, and Joseph G. Norby, Milwaukee, president-elect of the American Hospital Association, leading the discussion.

There will be a Forum on Monday evening, May 3, at 7:30, the subject of which will be "Pulling Toward a Common Goal: Better Service to the Hospital Patient—the Importance of the Professional Audit." The annual banquet and dance will be held in the Grand Ballroom on Tuesday evening at 7 o'clock, and the "Information Please" session, sponsored by the exhibitors at the Assembly, will take place on Wednesday afternoon.

University of Michigan Announces Postgraduate Courses

The University of Michigan Medical School has announced the following postgraduate courses for 1948:

Allergy, May 24–28. A short intensive program in the clinical phases of allergy. Illustration and case demonstrations. Methods of recognition and treatment. The practical aspects in the office management of allergic conditions.

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affecting the blood and blood-forming organs and their treatment. (1) Informal lectures illustrated by lantern slides and colored photomicrographs; (2) case presentations; (3) laboratory diagnosis, with demonstration of technical methods, and individual study of blood and bone marrow stained films.

Diseases of the Gastrointestinal Tract, May 17 to 21. The medical, surgical and roentgenological aspects of gastroenterological cases. Case demonstrations. Diagnosis and details of dietary and medicinal management of cases.

Diseases of the Heart, April 5 to 9. The recognition and management of heart conditions of especial interest to physicians in general practice. Present concepts and the more recent development in the management of heart disease, both from the standpoint of cardiac disease in general and particular types of heart disease.

Metabolism and Endocrinology, April 19 to 23. The newer knowledge in the fields of endocrinology and metabolism. Clinical recognition and diagnostic laboratory aids. Discussion of the biochemical abnormalities involved and presently accepted therapy.

Ophthalmology and Otolaryngology, May 3–8. A refresher program for specialists. Lectures, demonstrations and operative procedures by physicians of national prominence, as well as an opportunity to observe the application of modern developments in these specialties.

Pediatrics, April 14 to 16. Discussion of the anemias of childhood, the recognition and management of feeding problems in infancy, and the recognition and pediatric management of mentally defective infants and children. Practical clinical, therapeutic, and diagnostic technics, including laboratory procedures. Clinical case presentations.

Recent Advances in Therapeutics, June 1–4. A refresher program for the general practitioner. The subjects are general in nature. New concepts of therapy in the common medical conditions.

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Request for information should be addressed to Howard H. Cummings, M. D., Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

Annual Conference of American Physiotherapy Association

The American Physiotherapy Association will hold its annual conference at the LaSalle Hotel in Chicago, May 23–28. Among the subjects which will be discussed will be management of spinal cord injuries, nerve and tendon injuries of the hand, muscle reeducation, use of physical therapy for psychiatric patients, treatment of poliomyelitis, peripheral vascular disease, and the physiology of peripheral circulation.

Among the guest speakers will be Dr. Harry D. Bouman, professor of physical medicine at the University of Wisconsin Medical School.

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TRADE NEWS

Josiah Kirby Lilly, Dies

Josiah Kirby Lilly, chairman of the board of directors of Eli Lilly and Company, died on February 8. He was 86 years old.

Mr. Lilly was born in Greencastle, Indiana. His father, Colonel Eli Lilly, founded the company on May 10, 1876. Josiah Kirby, as a "boy with a wicker basket," delivered the first pound of a Lilly product to a near-by wholesale druggist. He was then 14 years old. In 1880 he entered the Philadelphia College of Pharmacy and Science, from which he graduated in 1882. Upon returning to Indianapolis he became superintendent of the plant, in which capacity he continued for about sixteen years. When Colonel Lilly died in June 1898, his son was elected president of the company. After thirty-four years as president, Mr. Lilly became chairman of the board of directors in 1932. He retired from active service with the company on January 1, 1945.

Schering Field Staff Increased

The addition of fourteen new representatives to Schering Professional Service staff has recently been announced by the Schering Corporation of Bloomfield and Union, New Jersey. Twelve of the new representatives have been assigned to the Domestic Sales Division for service in various territories throughout the country. Two representatives of the Schering Foreign Sales Division also completed the training course. These especially trained men are a part of the present Schering policy of expansion.

Winthrop-Stearns Has "Procaine Penicillin"

New improved penicillin, called "Procaine Penicillin," is now available through Winthrop–Stearns, Inc.

Company literature describes it as "a suspension of crystalline procaine penicillin G in sesame oil." After intramuscular injection, it forms a depot from which the penicillin is slowly released to the body. Hence, a small injection of only 1 cc. daily is generally sufficient instead of an injection every three hours as required with aqueous solutions.

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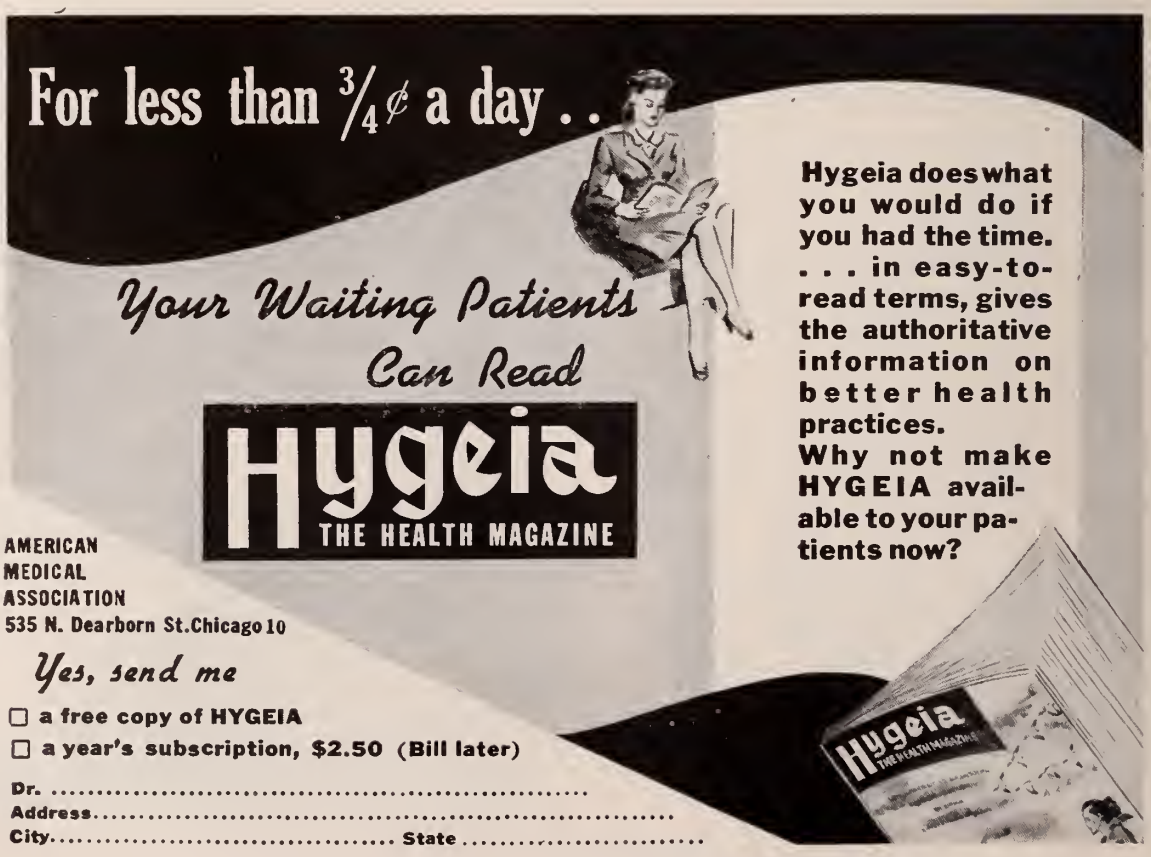

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	375
American Optical Co.	431
Ar-Ex Cosmetics, Inc.	418
Audiphone Utilities	434
Ayerst, McKenna & Harrison	371
Barr X-Ray Co.	437
Benson Optical Co.	365
Bergmann Prescription Pharmacy	415
Borden Co.	377
Camel (R. J. Reynolds Tobacco Co.)	370
Camp, S. H. & Co.	427
Central Drug	426
Ciba	374
Coca Cola Co.	364
Cook County Graduate School of Medicine	435
Doerflinger's	434
Drekmeier Drug	415
Endocrine Laboratories	430
First Central Dispensary	415
Hotel Schroeder	437
House of Bidwell, Inc.	437
Hurley X-Ray Co.	439
Ivanhoe Treatment, Inc.	443
Jensen Brothers	426
Kennedy–Mansfield Dairy	440
Lilly, Eli and Company	facing page 379
Lov-é Brassieres	417
M & R Dietetic Laboratories, Inc.	373
Mallatt Pharmacy	415
Mather Pharmacy	426
Mayer Drug	426
Mead Johnson & Co.	368, 442
Medical Protective Co.	376
Merck & Co., Inc.	421
Milwaukee Optical Co.	413
Milwaukee Sanitarium	444
Nechin, A. R. Co.	366
New World Life Insurance Co.	431
New York Polyclinic	437
Orthopedic Appliance Co., Inc.	432
Parke, Davis & Co.	362, 363, 429
Physicians Casualty Assn.	439
Physicians Radium Assn.	437
Pogue, Mary E. School	434
Prescription Pharmacy	415
Radium Service Corporation	432
Rennebohm Drug Stores	415
Rentschler Floral Co.	440
Roemer's	435
Rogers Memorial Sanitarium	444
Sacred Heart Sanitarium	415
St. Croixdale Sanitarium	365
Schering Corporation	419
Schlintz Bros. Drug Store	426
Searle, G. D. & Co.	411
Shorewood Hospital Sanitarium	413
Smith–Dorsey Company	367
Summit Hospital	428
Swift and Company	369
Upjohn	378
Wander Co.	372
Webster–Chicago	423
Winthrop–Stearns, Inc.	425
Zemmer Co.	416

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HELP WANTED: Associate wanted by physician doing general practice and general surgery in small town near large city. First class hospitals available. Prefer some one interested in internal medicine. Address replies to No. 137 in care of the Journal.

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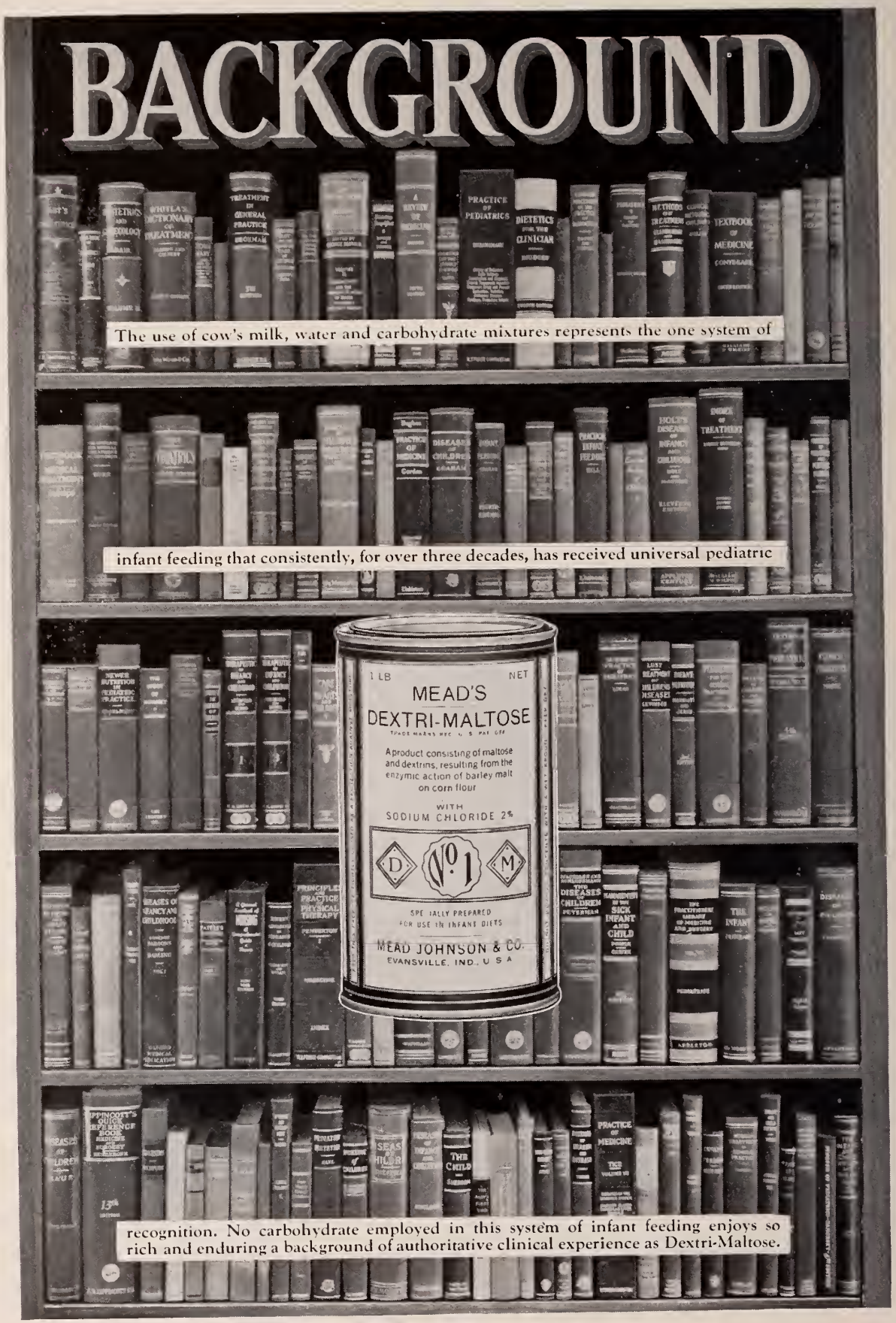
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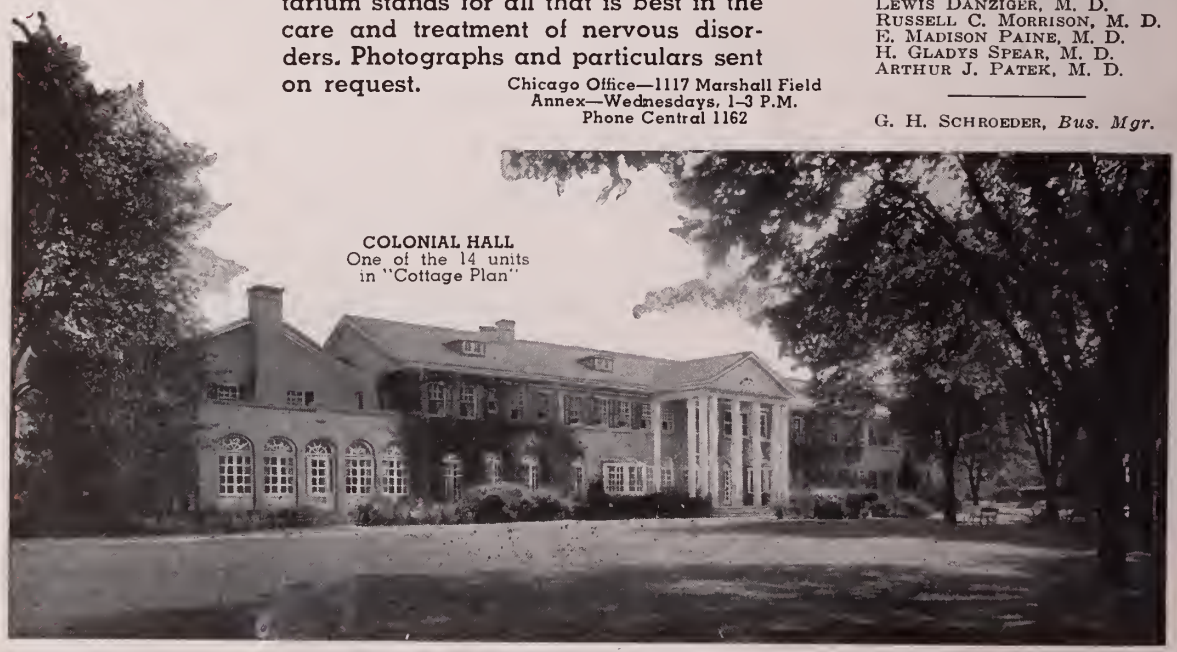

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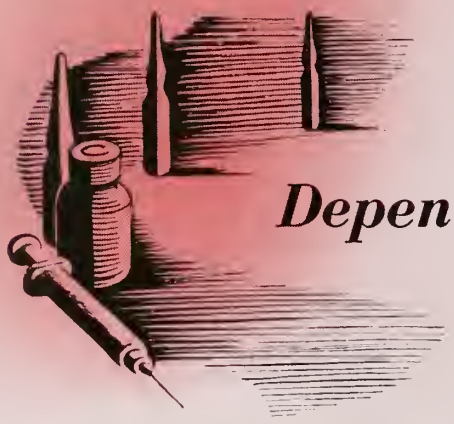

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Therapy in Epilepsy, by H. Houston Merritt, M. D., New York	463
Cyclodialysis and Iridectomy for Glaucoma with Cataract, by Lyman A. Copps, M. D., Marshfield	469
Management of Acute Cholecystitis, by Robert M. Zollinger, M. D., Columbus, Ohio	472
Anesthesia and Liver Function, by Frederick J. Pohle, M. D., Madison	476
The Treatment of Carcinoma of the Cervix, by Roland S. Cron, M. D., Milwaukee	480
Comments on Treatment	483
Notes on Clinical Pathology	484
As It Looks to Your State Board of Health	485

EDITORIAL

Spring Clinics	490

MISCELLANY

	Page
As It Looks from the Wisconsin Veterans Medical Service Agency	486
The President's Page	487
Spring Clinics	491
Annual Meeting News	492
Minutes of the Council Meeting, Madison, December 13, 1947	497
Minutes of the Council Meeting, Madison, January 31, 1948	503
News Items and Personals	514
Society Proceedings	516
And About the Third and Twelfth Districts	518
Society Records	520
Marriages	522
Deaths	522
Correspondence	526
The Woman's Auxiliary	528
The Journal Bookshelf	532
Physicians' Exchange	546
Index to Advertisers	548
List of Executive Officers of County Medical Societies	549

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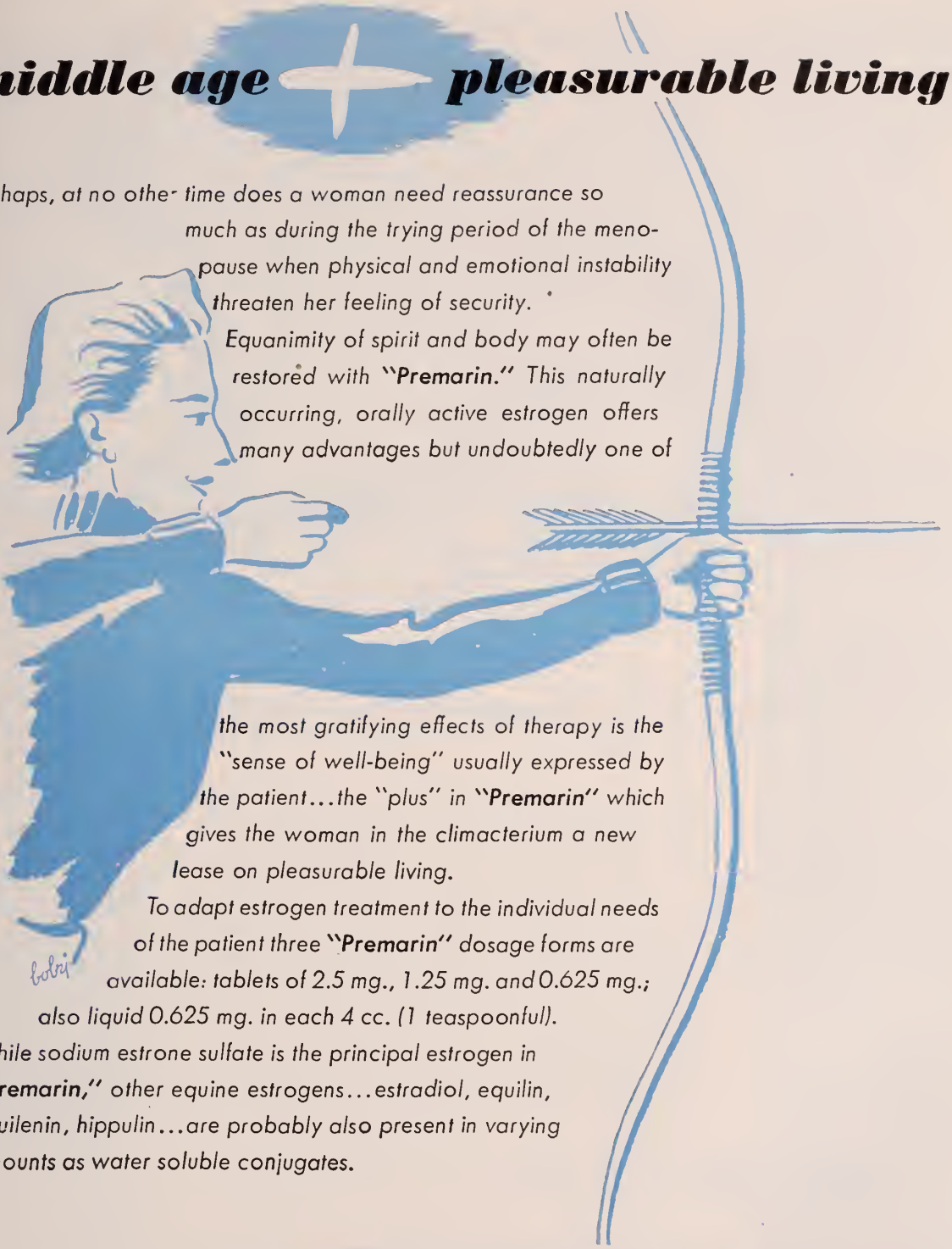

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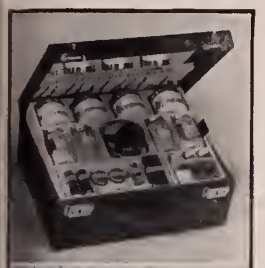

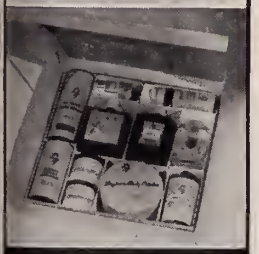

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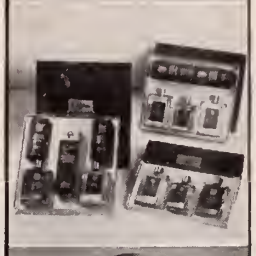

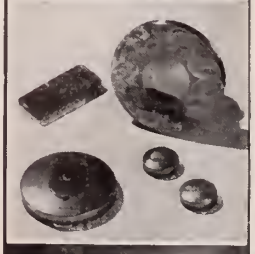

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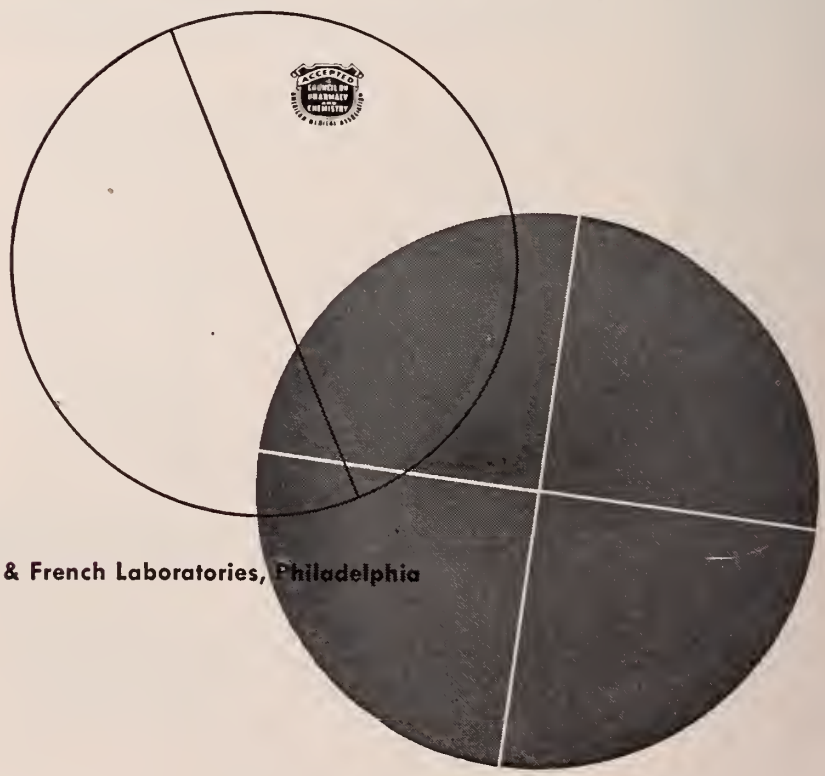

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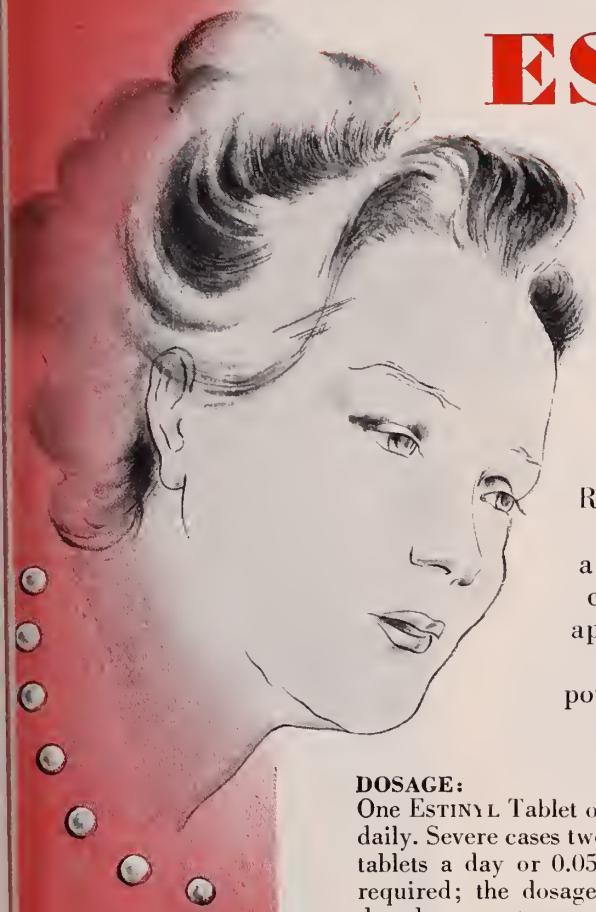

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1. Zondek, H.: The Diseases of The Endocrine Glands, ed. 4 (Second English), Baltimore, Williams & Wilkins Company, 1944, p. 421.

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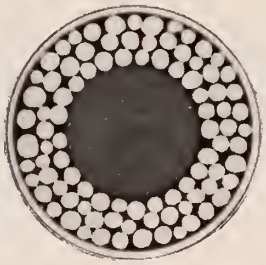

LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

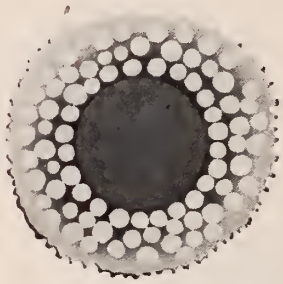

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Fig. 3 — Complete disintegration.

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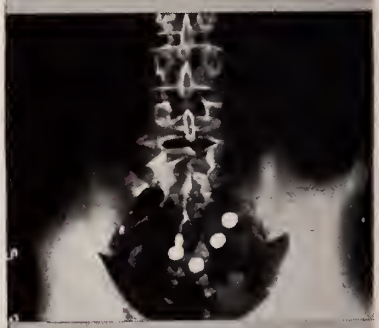
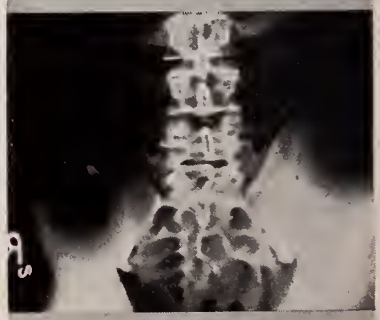


Four hours later . . . all tablets now in intestines.



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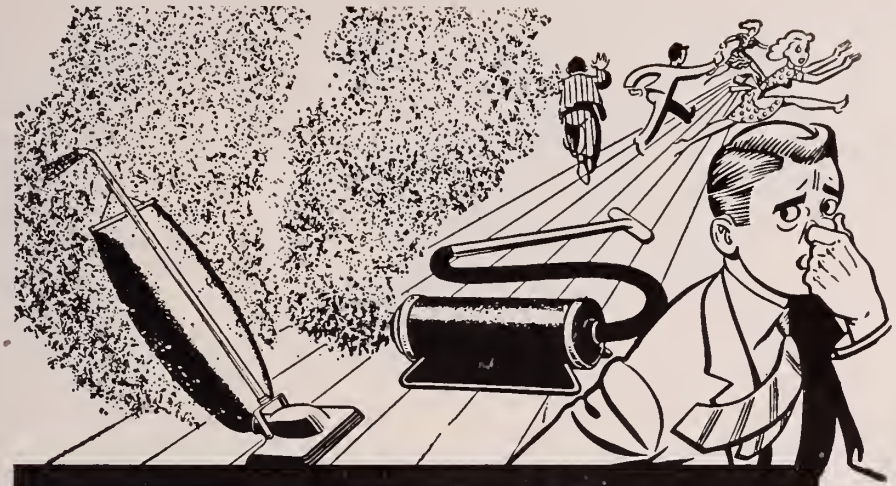

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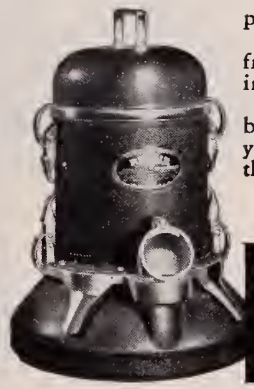

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1. *Texas State J. Med.* 52:683 (Apr.) 1947.
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3. *J.A.M.A.* 134:1141 (July 26) 1947.

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Therapy in Epilepsy*

By H. HOUSTON MERRITT, M. D.

New York

H. H. MERRITT

Doctor Merritt, professor of clinical neurology at Columbia University College of Physicians and Surgeons, graduated from Johns Hopkins University School of Medicine in 1926. After completing his internship and an assistant residency at New Haven, Connecticut, and a year's residency in neurology at Boston City Hospital, he became associate professor of neurology at Harvard University Medical School.

EPILEPSY is not a disease entity but is a symptom complex characterized by the periodic occurrence of transient disturbance of consciousness, with or without convulsive movements. Such a definition is inadequate, since the disturbance of consciousness may be so slight that it cannot be detected by superficial observation even though convulsive phenomena may be present. Recurrent attacks of loss of consciousness may occur in conditions not included in the category of epilepsy.

Classification

There are three ways of subdividing the patients with epilepsy, all of which have some value.

The first method divides the cases into two groups, symptomatic and idiopathic, according to the presence or absence of an organic lesion. The value of this division is that it emphasizes the fact that a thorough study of each case is a necessary preliminary to the application of the proper therapy. The concept of symptomatic and idiopathic epilepsy is a fallacious one, however, if we assume that it gives us any understanding of the underlying pathophysiology of the disease. It is erroneous to state that the seizures of patients with symptomatic epilepsy are due to the organic lesion in the central nervous system. This lesion is constantly present but the fits are irregular in occurrence. Furthermore, we are not in a position to state that a brain lesion is not present in the patient with so-called idiopathic epilepsy. We can only say that our present methods of examination fail to reveal such a lesion.

The second method of dividing the cases is that described by Penfield,[1] which is based mainly upon the site of origin in the brain of the epileptic discharge. The clinical manifestations of the seizures are dependent on whether the abnormal discharge which initiates the seizure is generalized, or localized to one particular region of the cerebrum. His method of separating the attacks is of special value to the neurosurgeon, who approaches the treatment of epilepsy from the surgical viewpoint, and is also of some value to the clinician in the choice of various treatment methods.

The third method of dividing the cases of epilepsy is based on the clinical manifestation which occurs during the seizure. This method of division of the cases is of particular value in the selection of the drug to be used in the therapy. Epileptic attacks may be divided roughly into three groups. Some patients may have only one type of seizure but it is rather common for the afflicted individual to suffer with two or even three types of spells. The three types of attacks are (1) petit mal, (2) grand mal (including Jacksonian), and (3) psychic equivalent or psychomotor attacks.

Petit mal attacks, which are characteristically a disease of childhood, are accompanied by transient clouding of consciousness lasting for only a few seconds, with or without minor movements of the head, eyes, and extremities. Other feature of petit mal epilepsy include transient loss of postural tone (cataplexy), myoclonic jerks, and the characteristic changes in the electroencephalogram. The phenomena which occur in a grand mal attack may be quite varied. Characteristically these attacks are ushered in by a warning (aura) and are followed by a sudden loss of consciousness with tonic-clonic spasms of the musculature, with or without urinary and fecal incontinence. Psychic equivalents or psychomotor attacks are terms used to describe a heterogenous group of epileptiform disturbances which do not conform to the classic grand mal or petit mal types of seizures. The milder psychomotor attacks are often confused with petit mal attacks, but they differ from the latter in that the duration of the period of mental cloudiness is longer and the range of muscular movements is greater. They differ from the grand mal attacks in that the patient does not

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

fall to the ground in a tonic-clonic seizure with complete loss of consciousness. In the severer form of psychic equivalents, the patient may be in a clouded mental state for many hours and perform acts of which he is entirely unaware.

Some understanding of the mechanism involved in the causation of convulsive seizures has been afforded by an analysis of electrical potentials of the cerebral cortex by the electroencephalogram. It has been shown by Gibbs and Lennox that with a seizure there are disturbances in the electrical activity of the cortex which are characteristic for each of the three forms of convulsive seizures described above. The electroencephalogram is of value not only in recording the changes that occur coincident with attacks but also in registering characteristic short bursts of abnormal activity in the interval between attacks. A vast majority of patients with seizures will show a paroxysmal abnormality of the electroencephalogram in the interval between attacks. The finding of an entirely normal electroencephalogram does not, however, exclude the diagnosis of epilepsy, since about 15 per cent of patients with epilepsy will have a normal record if only one tracing is taken in the seizure-free interval.

Treatment

Historical Review.—Various drugs were used by the ancient and medieval physicians, but the treatment methods of these times were mainly dietary restrictions, the invocation of supernatural powers, and the administration of substances which had magic properties.

In his comprehensive monograph on the falling sickness, Temkin[2] gives the various forms of treatment of the disease from ancient times to the latter part of the nineteenth century. The list of remedies for seizures, which are noted in his monograph, includes preparations of gold and coral, oil of vitriol, mistletoe, valerian, oxide of zinc, silver nitrate, turpentine, indigo, belladonna, henbane, and inhalations of chloroform.

The drugs which were used in the latter part of the nineteenth century as listed by Spratling,[3] included the bromides, opium, codeine, borax (suggested by Gowers in 1879), chloral hydrate, amylene hydrate, nitroglycerine, chloretone, zinc salts, urethane, solanum carolinense, simulo (made from a South American plant of the hyssop family), trional, iron, coal tar derivatives (phenacetin, antipyrin, and acetanalid), and chloroform. The introduction of the bromides as a therapeutic agent in epilepsy resulted from an interesting observation of Locock.[4] On the occasion of the presentation of a paper on the analysis of 52 cases of epilepsy by E. H. Sieveking[5] before the London Medico-Chirurgical Society on May 11, 1857, Dr. Charles Locock, the presiding officer, remarked that since the seizures in epilepsy were often related to hysteria or the menses, he had been led to try bromide of potassium by an observation made by a German physician that it was capable of producing temporary impotence. He had fourteen months previously prescribed bromides as a remedy in a case of epilepsy connected with sexual excitement, and, after all other medication had failed, the result had been an entire cessation of attacks. He had also tried the bromide of potassium in 14 or 15 similar cases, with failure in only 1. Sieveking[5] states in his monograph on epilepsy, which was published in 1858, that he had tried bromide of potassium in epilepsy but that his experience with the drug did not allow him to draw any definite conclusions.

The next advance in the pharmacologic treatment of epilepsy was the introduction of the use of luminal (phenobarbital) by Hauptmann[6] in 1912. This drug, which had been introduced as a sedative and a hypnotic, was used by Hauptmann, an assistant in Hoche's Clinic in Freiberg, for these purposes in epileptic patients. He administered it in daily doses of 0.3 gm. to patients with frequent and severe grand mal seizures. He reported favorable results in the patients, the number not stated, whom he had treated for six months. There was a reduction in the frequency of the attacks and a decrease in the severity of the attacks that did occur. He noted no untoward side effects from the use of the luminal. In fact, there was general improvement in the health and nutrition of the patients who had suffered from over-dosage of bromides. He noted that sudden withdrawal of the drug would result in the precipitation of a number of seizures.

Between 1912 and 1937 researches in the therapy of epilepsy were directed toward the modification of the internal milieu by restriction of fluids and by dietary measures rather than by the administration of drugs.

In 1921 Geyelin[7] demonstrated that fasting influenced the incidence of seizures in a certain number of the patients with epilepsy and suggested that the benefit was due to the acidosis induced by the fasting. This observation of Geyelin led to other methods of producing an acidosis. Wilder[8] at the Mayo Clinic demonstrated that a diet high in fat and extremely low in carbohydrate was as effective in producing acidosis as fasting. Wilder proposed the diet on the theory that acetoacetic acid should behave pharmacologically as an anesthetic. Other observers believed that a high fat diet owed its therapeutic value to its action on the acid-base equilibrium by correcting an abnormal tendency toward the spontaneous development of alkalosis.

Data which showed disturbance in the water balance in patients with epilepsy were presented by Gamble[9] in 1923. McQuarrie[10] in 1929 demonstrated that a negative fluid balance tended to reduce the frequency of seizures. The greatest advocate of the dehydration therapy, however, was Temple Fay[11] of Philadelphia. The excessive restriction of fluid intake necessary to maintain a negative fluid balance negated any wide acceptance of this form of treatment.

In 1937 a new method of testing the anticonvulsive activity of drugs in animals was devised by Putnam and Merritt.[12] By this method a larger number of compounds were tested and a number of them were found to have an anticonvulsant activity greater than those already in common use. One of these compounds, sodium diphenyl hydantoinate (phenytoin sodium, dilantin sodium, epanutin),[13] was introduced into the treatment of epilepsy. The results obtained with sodium diphenyl hydantoinate have led to the successful trial of other hydantoin derivatives[14] and to the synthesis of another compound known as 5,5,5-trimethyloxazolidine-2,4-dione (tridione).[15]

Modern Treatment of Epilepsy.—The present day treatment of patients with convulsive seizures can be divided into three categories: (1) elimination of the factors of importance in the causation or precipitation of attacks, (2) general mental and physical hygiene, and (3) medical therapy directed toward elevation of the convulsive threshold and thus the prevention of attacks.

1. The elimination of the factors of importance in the causation of seizures requires treatment of all underlying physiologic or structural abnormalities which have been discovered in the thorough examination of the patient. This includes surgical removal of operable tumors of the brain, evacuation of brain abscess, treatment of infections or endocrine abnormalities such as hypoparathyroidism or hyperinsulinism, and the correction of any physical defects. The question of the advisability of removing scar tissue resulting from traumatic or vascular injuries to the brain will be discussed more fully later.

2. Mental and physical hygiene. It is only rarely that the elimination of causative factors indicated above will result in the disappearance of attacks; in the vast majority of patients, control of the attacks requires, in addition, regulation of the physical and mental hygiene and the administration of anticonvulsive remedies. It must be remembered that the period of treatment in the majority of patients is measured in terms of years or in a life time. Patients must be encouraged to use all of their resources to overcome their feelings of inferiority and self-consciousness resulting from the attacks. Adults should be assisted in obtaining some productive work which will occupy their time and give them some remuneration. Children should be kept in school unless the frequency of attacks unduly disturbs the routine of the classroom or unless mental deterioration requires special facilities. A long-continued schedule of psychotherapy is of value in some patients in aiding them to adjust to their difficulties, but it cannot be expected to have any significant effect on the frequency of the attacks. Education of other members of the family in regard to their attitude toward the patient's illness is of great importance. Excessive attention and oversolicitousness should be eliminated, and the family should not be allowed to make a chronic invalid of the patient.

Physical activity of the patient should be regulated so that there is a set time for eating and sleeping and regular exercises every day. These exercises should be of a moderate nature and the patient should not participate in competitive sports to the point of exhaustion. Meals should be wholesome and of a simple nature, with the proper amount of carbohydrates and proteins and an abundance of fresh fruits and vegetables. Alcoholic beverages are to be absolutely avoided. Bowels can be regulated by training and, if necessary, by the judicious use of mild laxatives. The patient should have a set time for retiring and arising and should not be allowed to stay in bed after the other members of the household have arisen. Special activities, such as parties, dancing, moving pictures, and so on, should be encouraged. Swimming, horse back riding, and other dangerous sports can be permitted when there are proper safeguards. The risk involved in such activities is justified in most instances in order to prevent the development of chronic invalidism. Activities which endanger the lives of others, such as driving of automobiles, should be prohibited. Commitment of the patient to an institution is not desirable unless mental deterioration or undue violent or frequent attacks not controllable by treatment make it necessary. On the other hand, definitely deteriorated, destructive, or dangerous patients should not be kept at home and allowed to ruin the lives of other members of the family.

3. Medical therapy. The efforts directed toward the social and mental hygiene of the patient are of great importance, but the success of such measures depends to a large extent upon the ability of the physician to prevent the occurrence of seizures. There are effective measures at hand for the prevention of seizures, and they should be given an adequate, thorough trial in each individual patient. The most effective method for the control of seizures is the use of the anticonvulsive drugs, namely, phenobarbital, phenytoin sodium (dilantin sodium), and bromides. Other forms of treatment such as the ketogenic diet and dehydration have been discarded by most physicians.

The decision regarding which drugs should be used in a given case depends somewhat on the nature of the attacks and the age of the patient. It is important to remember that, if satisfactory results are not obtained with one of these drugs, the others should be tried. In some patients a combination of two or more of the drugs will yield much better results than the use of one alone.

Indications for the Use of Specific Drugs.—Phenobarbital can be tried first in the treatment of patients with infrequent grand mal seizures because of the high therapeutic index and the relatively low toxicity of this drug. If satisfactory results are not obtained, phenytoin sodium should be tried. A combination of phenobarbital and phenytoin sodium is often more effective than either one of the drugs when used alone. It must be remembered that in using these drugs in combina-

tion, a full therapeutic dose of each drug must be used. In patients with frequent grand mal seizures or attacks of the psychic equivalent or psychomotor type, phenytoin sodium is the drug of choice. Tridione is the drug of choice in the treatment of petit mal attacks in children. Glutamic acid has been reported to be of value in the treatment of petit mal attacks, but we have not been impressed with the results obtained with this form of therapy.

Dosages To Be Used.—Phenobarbital: For the average adult the initial dose of phenobarbital should be 1½ grains daily. This can be given at bed time. If after a trial period of two weeks or as long as is necessary to determine whether this dose is effective, further increases can be made in the dosage until the patient is taking as much as 4½ to 6 grains per day. If this amount of the drug is not sufficient to control the seizures, it is probable that a further increase will not be of value. In children, the dose of phenobarbital should be in proportion to weight, but it has been found that children are able to tolerate and require almost as large a dose as adults. It is, therefore, advisable to give children over 6 or 7 years of age the minimum dose of 1½ grains per day. The toxic symptoms of phenobarbital are well known and need no further discussion. Drowsiness is common at the start of the treatment but this disappears with continued use of the medicine in the majority of patients, and it is only occasionally necessary to discontinue this treatment because of its persistence.

Phenytoin Sodium: Phenytoin Sodium (dilantin sodium) is 5,5-diphenyl glycolyl urea. The value of this drug in the therapy of convulsive seizures was first reported in 1938.[13] It is particularly valuable in the treatment of psychomotor and grand mal attacks. This drug has the advantage over phenobarbital and the bromides in that it has very little or no hypnotic activity. The regulation of the dosage is more difficult, however, and minor toxic symptoms are more frequent. The toxic symptoms[16] are not serious and it is almost impossible for a patient to take a fatal dose of the medicine.

The principle of administration of phenytoin sodium is similar to that of phenobarbital, that is, the establishment and maintenance of a reservoir of the drug sufficient to control the seizures. In the average adult, the initial dose should be 1½ grains (0.1 gm.) three times daily. If any seizures occur after two weeks of this dosage, it should be increased to 6 grains (0.4 gm.) daily. Further increases in the dosage should be by increments of 1½ grains (0.1 gm. until the maximum dose of 9 grains (0.6 gm.) daily is reached. In the majority of adults, 6 grains (0.4 gm.) is the optimum dose. In children over 12 or 14 years, the average dose is 4½ grains to 6 grains (0.3 to 0.4 gm.) and in younger children 3 to 4½ grains (0.2 to 0.3 gm). The medicine can be given in divided doses spread out through the day, or it can be given all in one dose at bed time. The drug is quite alkaline and it may cause gastric upsets. This can be prevented by giving the drug along with the meal or with some food.

The toxic symptoms of phenytoin sodium are different from those of phenobarbital in that nervousness or sleeplessness, rather than drowsiness, is more commonly an early symptom. Other toxic symptoms are gastric distress, nausea and vomiting, unsteadiness of gait, hypertrophy of the gums, dermatitis, and psychotic symptoms.

The minor toxic symptoms are frequently transient and may disappear with continuation of the therapy or when the dosage is temporarily reduced. Nystagmus and ataxia can be produced in practically all patients if the dosage is raised sufficiently high. A few adults will tolerate as much as 9 to 12 grains (0.6 to 0.8 gm.) but symptoms usually develop when the dose is increased beyond 7½ grains (0.5 gm). The appearance of toxic symptoms calls for a temporary or permanent reduction of the dosage. If the reduced dose is not effective in controlling the seizures and attempts to increase the dose again result in the appearance of toxic symptoms, a combination of phenytoin sodium and phenobarbital or bromides should be tried, or one of the other hydantoins, such as mesantoin, should be substituted.

Gastric discomfort, nausea, and vomiting may be controlled by the administration of the drug along with a little bicarbonate of soda or at meal time. Dermatitis occurs within two weeks of institution of therapy in approximately 5 to 10 per cent of the patients and is usually of a scarlatiniform or morbilliform nature and is accompanied by fever. The rash usually disappears within a few days after withdrawal of the drug. Recurrence of the rash when treatment is reinstituted or the development of an exfoliative dermatitis precludes further use of the medicine.

One of the troublesome toxic symptoms of the drug is hypertrophy of the gums. This is most common in children and varies from a slight swelling of the gums to a marked hyperplasia with almost a total covering of the teeth. The hyperplastic tissue is usually quite firm without any tendency to bleeding and is not related to any disturbance in the absorption or utilization of vitamin C. This swelling of the gums can be retarded by daily massage of the gums. Excessive growth of the gum tissue can be excised by the electric cautery. The development of psychotic symptoms in patients under therapy with phenytoin sodium is rare and it is usually not possible to determine whether these symptoms are related to the use of the drug or not. In such cases a change in the type of treatment should be tried.

Other Hydantoins: Various derivatives of the hydantoins have anticonvulsive properties. In some patients one of these hydantoin derivatives may be more effective in controlling grand mal or psychomotor seizures than either phenobarbital or phenytoin sodium. The work on the majority of these drugs is still in the experimental stage, with the

exception of the 3-methyl, 5-phenyl, 5-ethyl derivative, which has been given an extensive clinical trial by Lascalzo[14] and Kozol.[14]

Kozol reported on the use of 3-methyl-5,5-phenylethylhydantoin (mesantoin) in 104 patients who were treated for an average of ten months. Nineteen per cent were seizure free (three to twenty-two months) and 41 per cent were greatly or moderately improved. The average dose for children was 0.4 gm. daily, and for adults, 0.6 gm. The maximum daily dose was 1.0 gm. The drug was often used in combination with phenytoin sodium. The most common symptom of overdose was drowsiness. Toxic rash also developed in a few patients. A number of cases were cited in which good results were obtained in patients previously uncontrolled with phenytoin sodium (alone or with phenobarbital), but no precise comparison of the efficacy of phenytoin sodium and mesantoin was attempted.

Bromides: Bromides, which were formerly the main therapeutic agent in epilepsy, have been replaced almost entirely by phenobarbital and the hydantoins. They are, however, occasionally effective when other forms of therapy fail. Although any of the salts may be used, the drug is most commonly given as the sodium or potassium salt, in tablets, or aqueous solution. The average dose for an adult is 15 grains (1 gm.) three times daily with proportionate doses to children according to size. In the absence of toxic symptoms this dose can be increased to a maximum of 30 grains (2 gm.) three times daily. The chloride intake must be kept at an adequate level to prevent undue replacement of chloride ion in the body fluid by the bromide. Facilities for the determination of the bromide content of the serum should be available. The effective level may be as low as 100 mg. per hundred cubic centimeters in some patients, whereas 300 mg. per hundred cubic centimeters may not be effective in others. Toxic symptoms usually develop with a concentration of 150 mg. or greater. The chief objections to the use of bromides lie in the frequency of the development of skin rash, toxic psychosis, and their reputed tendency to produce mental dullness.

Combination of Phenytoin Sodium with Phenobarbital, Bromides, or Mesantoin: Since phenytoin sodium has very little sedative effect, it is particularly adapted to use in combination with phenobarbital, the bromides, or mesantoin. Various combinations can be used when one drug is not effective in controlling the seizures or when the effective dose of phenytoin sodium alone produces toxic symptoms. The doses of the combination must be worked out according to the tolerance of each patient. Three to five doses a day of a combination of 1½ grains (0.1 gm.) phenytoin sodium with ½ grain (0.06 gm.) of phenobarbital, 15 grains (1 gm.) sodium bromide, or 0.1 gm. of mesantoin are usually required in the more resistant cases.

Other Forms of Therapy.—Ketogenic Diet: It has been shown that a shift in the acid-base balance of the body fluid to the acid side tends to prevent seizures. This can be accomplished by the ingestion of acid or acid-forming salts, but the use of such substances for long periods is not desirable. A satisfactory acidosis can be produced by a diet which contains an excess of fats over carbohydrates. Good results in the control of seizures by this diet have been reported by numerous observers. As stated before, however, patients that respond to this form of therapy usually respond to phenobarbital or phenytoin sodium therapy, and since the administration of these drugs is a simpler procedure than the establishment of ketosis, the ketogenic diet has fallen into disuse.

Glutamic Acid: The use of glutamic acid as an adjuvant in the treatment of convulsive seizures, was suggested by Price, Waelsch, and Putnam[17] in 1943. These authors found that glutamic acid when used by itself had no effect on grand mal seizures, but when it was used in combination with phenytoin sodium or phenobarbital it tended to reduce the frequency of petit mal or psychomotor seizures in children and was also effective in controlling behavior difficulties in these children. Very large doses of the glutamic acid are required, that is, 8 to 20 gm. per day.

Tridione (3,5,5-trimethyloxazolidine-2,4 dione): The introduction of tridione[15] has given the medical profession for the first time an effective treatment of petit mal seizures. The use[18] of this drug is accompanied by a cessation or reduction in frequency of petit mal attacks in approximately 50 per cent of the cases. In a few patients the cessation of attacks is accompanied by a decrease in the abnormalities in the electroencephalogram. In such patients it is sometimes possible to discontinue the use of the drug without recurrence of the petit mal seizures. The drug is of no value in the control of grand mal or psychomotor seizures. If patients are subject to one of the latter types of seizures as well as petit mal, phenytoin sodium or phenobarbital should be given along with the tridione.

The dosage of tridione for the treatment of petit mal varies from 0.3 to 2.0 gm. daily, starting with 0.3 gm. and gradually increasing the dose until the seizures are controlled or toxic symptoms appear. Among the toxic symptoms are skin rashes, which require a cessation of the treatment, and visual symptoms—an unusual sensitivity to light. This latter symptom is apt to develop in adolescent or adult patients and is uncommon in young children. The photophobia is not accompanied by any change in visual acuity, and it disappears when the medicine is discontinued.

Two cases of fatal aplastic anemia following the exhibition of tridione for periods of six and ten months have been reported.[19] Prolonged use of the drug may also be accompanied by a decrease in the percentage of polymorphonuclear leukocytes in the blood without an absolute decrease in the total number of leukocytes. Although it is not known whether

the observation of any precautions will make it possible to prevent serious or fatal changes in the blood, it is recommended that routine blood count be made monthly in patients using tridione. The drug should be discontinued if any significant changes are found.

Status Epilepticus

Patients who are subject to seizures may have attacks so frequently that they do not recover from the coma produced by one attack before the next attack supervenes. The patient remains in coma for twelve to twenty-four hours, during which time there may be many convulsive seizures. The attacks may cease spontaneously and the patient recover consciousness after a period of twenty-four to forty-eight hours, or death may occur as the result of the repeated attacks. The likelihood of the latter eventuality is so great that vigorous therapeutic methods aimed at terminating the seizures are justified. Good results in regard to termination of the attacks can sometimes be obtained by anesthetizing the patient with one of the volatile anesthetics such as chloroform or ether. Termination of the seizures is more certain with the injection of sodium phenobarbital or paraldehyde intravenously and there is less risk of pulmonary complications. It is important that a large dose be given at the first injection because best results are obtained when the full amount is given in one rather than in divided doses. For status epilepticus in adults 6 to 12 grains (0.4 to 0.8 gm.) of sodium phenobarbital dissolved in distilled water or 3 to 6 cc. of paraldehyde should be injected intravenously. The dosage for children is 3 to 6 grains (0.2 to 0.4 gm.) of sodium phenobarbital or 2 to 4 cc. of paraldehyde, according to the size of the child.

Surgical Treatment

Whenever convulsive seizures are associated with a surgically removable lesion of the brain, such as tumor or abscess, removal of such a lesion is indicated. It must be remembered, however, that the relief of convulsive seizures will result in only about 50 per cent of cases of meningioma of the brain and in a much smaller percentage of cases of glioma or abscess of the brain. In such cases, further treatment with drugs is necessary.

In addition to the removal of expanding lesions, surgery has been advocated for the removal of cortical scars secondary to cerebral trauma, vascular lesions and birth injuries on the assumption that such scars produce irritation of the neighboring cortex and act as a trigger mechanism for the seizures. This form of treatment should be limited to the group of patients with focal attacks which do not respond to medical therapy. In addition, the excision of such lesions should be performed only by neurosurgeons who have the facilities for adequate localization of the abnormal focus in the cortex which is acting as the "trigger-mechanism" for the seizures. This focus may not be in the actual scar but in apparently normal brain tissue at several centimeters removed from the scar. Medical treatment must also be used in these patients after operation.

The excision of isolated foci of abnormal electrical activity (as shown by the electroencephalogram) is still in the experimental stage and is not to be advised as yet, since it is possible that the excision of such abnormal foci will result only in the shifting of the abnormality to another region of the cortex.

Operations other than on the central nervous system are not advisable unless indicated for reasons apart from the occurrence of convulsive seizures. Removal of the cervical sympathetics or portions of the large intestine, operation on the sinuses, and the like, have no effect on the ultimate course of the seizures. Removal of tumors of the pancreas is, of course, necessary when attacks are definitely proved to be related to hyperinsulinism. Removal of the carotid sinus may be of benefit in patients with carotid sinus syncope.

Summary

Research in epilepsy in the past decade has given us additional insight into the nature of the disease through the application of the electroencephalogram and from the practical viewpoint of the clinician it has been signalized by the introduction of several new drugs which are effective in the control of seizures.

The success which can be obtained in the treatment of patients with epilepsy depends upon the ability of the physician to evaluate the role of various etiologic factors in each case and his skill in administration of therapy. The choice of the drug, or drugs to be used in medical treatment of the patient should be governed by the type of seizures which occur in the patient and the reaction of the patient to the various drugs. If one drug is not effective, another, or a combination of two or more drugs should be tried. Dosages cannot be standardized according to age or the weight of the patient. Failure to obtain good results is often due to the use of an inadequate dose.

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Cyclodialysis and Iridectomy for Glaucoma with Cataract*

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CATARACT often is found in glaucomatous eyes, and many of these eyes require surgery for both conditions. Sometimes a cataract operation can be combined with a sclerectomy or iridectomy so that one operation satisfies them both. More often the glaucoma operation is done first and the lens extraction later. It is not good surgery to do an extraction on an eye which has an elevated tension; the tension should be under control as a result of medical or surgical care at the time of the extraction and preferably for some time preceding it. The many varieties of operations and their adaptations to the different types of glaucoma have been discussed widely, but less mention is given to the procedure of lens extraction in an eye on which a successful filtration operation has been done.

On the assumption that it is a bad principle to disturb a well functioning fistula operation, many surgeons prefer to extract the lens through an inferior incision; others make a corneal section below the fistula. It is possible to cut boldly across a trephine opening and extract the lens through the usual limbus incision without ill effects. It would seem safer to dissect downward the original conjunctival flap and make the limbus section beneath it across the trephine opening or by enlarging the iridencleisis incision.

It has been said that the surgeon who is operating for glaucoma should devote his entire attention to the curing of the glaucoma, assuming that someone else is going to extract the cataract if one is present. It is better planning to consider the problem in its entirety and to plan the procedure or procedures necessary to provide vision in the eye in advance.

With cataract and glaucoma, O'Brien[1] prefers a combined sclerectomy (Lagrange) and cataract extraction. Some surgeons like to do a preliminary iridectomy; others do the cataract extraction and make a wide complete iridectomy or iris inclusion operation. Guyton[2] says that if the glaucoma is non-

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congestive and cannot be controlled with miotics, an anterior fistulizing operation should be done prior to the cataract extraction, and if it can be controlled with miotics or if it is chronic congestive, a combined cataract extraction should be the initial procedure and is likely to be the only operation necessary. This is very sound logic, particularly as regards the chronic simple glaucoma which can be controlled with miotics. In other cases, if a type of glaucoma operation can be done which will facilitate the lens extraction and at the same time be reasonably sure to control the tension, it would be the best operation to do. This condition is very satisfactorily satisfied if a simple root iridectomy is indicated for the glaucoma.

In chronic simple glaucoma, a plain iridectomy will rarely suffice, for reasons which we all know. This is unfortunate, especially since a preliminary iridectomy does facilitate the cataract extraction, and it is routinely done by quite a number of surgeons.

Before the iridectomy, if the iris root can be freed from its adhesion to the posterior surface of the cornea so that the chamber angle is freely opened, the iris can, at the time of iridectomy, be drawn well out of the eye and cut off at its root, and the desired access of aqueous to the trabeculum and Schlemm's canal is provided. This can be done by cyclodialysis, which has the added advantage of opening the suprachoroidal space to the aqueous. Cyclodialysis and iridectomy can be done in two stages; however, if they are done at one operation, there is no possibility that the iris may readhere to the posterior surface of the cornea before the iridectomy is done, and there is the added advantage of reducing the number of operations on the eye. The cyclodialysis leaves an eye upon which a cataract operation can be done with no unusual difficulty. In our hands, cyclodialysis in chronic simple or chronic congestive glaucoma has not been successful and permanent enough in a large enough proportion of cases for us to feel that we can depend upon it in the type of case I am discussing.

Barkan[3] and others have demonstrated that the success of cyclodialysis depends upon the establishment of free communication between the anterior chamber and the suprachoroidea. If the iris root is removed immediately after the cyclodialysis, this communication will more probably remain.

The idea of combining cyclodialysis with iridectomy is not new. In 1923 Torok[4] reported the operation, in 1927 Jervey[5] reported a case, and in 1932 Wootton[6] discussed a technic for the combined operation, which varies somewhat from that which we have used. Wheeler[7] recommended the operation for advanced and desperate cases and considered it too traumatizing for ordinary cases.

I do not recommend it for general use in glaucoma, even though I do not find it unduly traumatizing, but my experience leads me to believe that it may be suited to those cases of glaucoma which cannot be controlled with miotics, in which cataract extraction is to follow later, and in which gonioscopy reveals that the sinus is not open. I have not found it more traumatizing than other eye operations, and the healing period has not been prolonged much, if any, beyond that of other operations for glaucoma.

Technic of Operation

The operation is done with the patient under local anesthesia. Butyn 2 per cent is first instilled into the conjunctival sac. A retrobulbar injection of 2 cc. of procaine hydrochloride with 3 minims of epinephrine hydrochloride is made, and 2 minims of 5 per cent cocaine hydrochloride are injected subconjunctivally at 12 o'clock near the limbus. Cocaine is used here because it controls the pain associated with the dialyzing process better than any other anesthetic. A curved incision is made through the conjunctiva and Tenon's capsule 7 or 8 mm. above the limbus and parallel to it. The sclera is laid bare to the limbus widely enough to permit a satisfactory limbus incision, at least from 10:30 to 1:30. It is extremely important that a minimum of aqueous be lost while doing the cyclodialysis, and for this reason the incision through the sclera is made just wide enough to admit the spatula. This incision is made below the insertion of the superior rectus 5 or 6 mm. above the limbus at 12 o'clock. It is made with a keratome or cataract knife obliquely downward through the sclera by short scratch cuts. If the surgeon wishes to control the eyeball with O'Brien's scleral fixation suture, it must be placed before the scleral incision is made. If not, the sclera is grasped at 6 o'clock with a narrow-toothed scleral fixation forcep and depressed sharply. A narrow-bladed angulated spatula is introduced into the suprachoroidal space, and, hugging the sclera closely, it is brought downward into the chamber. Then by gentle pushing movements from above downward, the ciliary body is separated from the scleral spur. It is important to hold the spatula close to the sclera to prevent opening a channel through which aqueous can escape. After withdrawing the spatula, the conjunctiva is lifted and a sharp keratome introduced into the chamber through the limbus. If the keratome incision cannot be made wide enough without endangering the lens, it can be enlarged with scissors. The iris is grasped widely and drawn out of the eyeball with good traction. The scissors hugs the sclera closely and cuts off the iris with three or four snips, the first and last cutting the sphincter. If iris remains caught in the ends of the incision, it is replaced with the spatula. If hemorrhage into the chamber has occurred during the cyclodialysis, it may be washed out with the chamber irrigator. The conjunctival incision is closed with fine silk and atropine instilled.

Thus far, this operation has been done by me only in advanced cases of glaucoma in which it seemed imperative to control the tension in one operation, in which a minimum of surgery was desirable, and in which a large part of the chamber angle was found closed by gonioscopic examination.

Report of Cases

The following cases are presented:

CASE 1.—Mrs. C. H., aged 73, had a gradual decrease in vision for several years. The cornea was small (10 mm.), chambers very shallow, and pupils irregular in outline and about 4 mm. in diameter. Both nuclei were clouded. There was good red reflex in each eye, but no fundus detail was visible. Vision in the right eye was 0.3, and in the left, 0.1. Tension (Schiotz) in the right eye was 29 mm. and in the left 35. Under miotics (pilocarpine) the pupils were brought down to 1½ mm., but tension remained at or above 27 mm. in the right and 30 mm. in the left. Cyclodialysis and iridectomy were done on the left eye and a month later on the right. The tension in both has remained in the neighborhood of 17 mm. ever since. Six and a half months after the first operation on the left eye, the cataract was extracted from that eye. Later, vision was improved to 0.4 in that eye with correction. The cataract in the right eye has not been removed for the reason that the patient is satisfied with her present vision.

CASE 2.—Mrs. J. H., aged 79, had diminishing vision for several years. There were no further symptoms. The corneae measured 10½ mm., chambers were shallow, pupils measured 3 mm., the right nucleus was slightly clouded and left moderately clouded, and there were many fine peripheral ryders in both. The right disc was slightly atrophic, but not definitely cupped; the left disc was not visible. Right vision was 0.4, and left vision 0.2. Tension in the right eye was 28 mm. and in the left, 32. Cyclodialysis and iridectomy were done on the left eye. For three years the tension in this eye remained under 21 mm. The cataract was then extracted from this eye and corrected vision of 0.6 obtained. The tension in this eye has remained normal. The other eye has never been operated upon.

CASE 3.—Wm. R., aged 76, had failing vision for five or more years. There had been no pain ever. There were large corneae and deep chambers, the right pupil measured 5 mm. and the left 4½ mm., both nuclei were moderately clouded, the right disc was cupped 3D and pale, and the left disc was cupped 1D and pale. There were many peripheral ryders in both lenses. Tension (Schiotz) in the right and left eyes was 30 mm. There was no light perception in the right and 0.2 vision with correction in the left. The left fields were contracted to 10 and 15 degrees. Since the eye was a poor surgical risk, miotic treatment was employed with satisfactory contraction of the pupils, but the tension remained above normal and the vision declined. With the hope of retaining some vision, on May 14, 1941, with a tension of 30 mm. and vision of 5/200, cyclodialysis and iridectomy were done. At this time the lens opacities had increased so that no fundus view was obtainable. Following this, the vision improved to 8/200. The tension remained under 15 mm., but vision decreased because of the increasing lens opacity. Four years after the first operation, the lens was extracted and vision of 3/200 with correction was obtained. This vision has remained and the tension is in the neighborhood of 14 mm.

CASE 4.—Mrs. M. D., aged 81, eight months prior to the first examination, had had an attack of acute inflammatory glaucoma with loss of vision of the right eye. The vision in the left eye was 0.2. The eye was white, the cornea slightly smaller than normal, and the chamber moderately shallow; the pupil was 5 mm. in diameter, the lens nucleus evenly clouded, and there were many narrow ryders in the peripheral cortex. There was a good red reflex, but no fundus detail could be seen. The tension was 28 mm. (Schiotz). The tension was controlled with pilocarpine, and combined lens extraction was advised and refused. Six months later she had neglected her drops, and she came in with a tension of 36 mm. and vision of 0.1. Tension could not be brought under 25 with miotics. Combined cyclodialysis and iridectomy were done. Following this, the tension has remained normal and the vision was 0.2. Four months later the lens was extracted and the resultant vision with correction is 0.3, the tension remaining normal.

CASE 5.—J. F., aged 67, had gradually diminishing vision for an indefinite time. The absence of vision in the right eye was first discovered at examination. The patient did not realize that there was anything wrong with the left eye. Both eyes were white, the corneae were slightly smaller than normal, and the chambers were slightly more shallow than normal. Both lens nuclei were slightly clouded and there were many peripheral ryders in the left. The right disc was very pale and cupped 2D. The left disc was very slightly pale and slightly cupped. There was no light perception in the right and 0.6 vision with correction in the left. There was slight nasal contraction of the left field. The tension was 45 mm. in the right and 36 mm. in the left.

The patient was observed for six months, during which time vision declined slightly in the left eye, and occasionally he would come in with a tension as high as 42 mm. in spite of what he said was faithful use of the drops. A combined cyclodialysis and iridectomy were done on the left eye. The vision dropped to 0.4 and tension remained under 18 mm. A year and a half later his lens was clouded so that the disc could not be seen clearly, vision was 0.2, and the lens was extracted. The resultant vision is 0.6 with correction and tension normal.

In all of the above cases, gonioscopic examination after operation revealed that there was free access of aqueous to the chamber angle.

This operation was done in 2 cases of acute congestive glaucoma without success in either case. In another case, the capsule tore in attempting an intracapsular extraction and soft lens cortex was left in the eye in spite of chamber irrigation. This cortical material apparently blocked the chamber angle and tension returned quickly; vision in this eye was eventually lost. The experience with this eye indicates that intracapsular extraction is better in these cases.

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Management of Acute Cholecystitis*

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IT IS doubtful whether the over-all mortality rate for acute cholecystitis has been appreciably lowered in recent years in comparison with that of other common surgical conditions such as acute appendicitis. This situation may be the result of many factors. In the first place, acute cholecystitis is a common but serious complication of the cholelithiasis so prevalent in the elderly; furthermore, there is a tendency to underestimate the potential seriousness of this acute surgical problem, since gradual recovery without surgery is more certain than in acute appendicitis. A false sense of security in the effectiveness of chemotherapy may also play a significant role. Some confusion has arisen due to the recommendation of contradictory plans of treatment. These range from early operation, as in appendicitis, to delayed surgery until the acute manifestations of the disease have entirely subsided. It is desirable, therefore, for the physician to review from time to time his own management of gallbladder disease to ascertain whether his methods assure the lowest possible morbidity and mortality.

Perhaps more thought should be given to the preventive aspects of acute cholecystitis by advising surgery immediately following the initial discovery of gallbladder disease, regardless of the age of the patient. The risks of surgery as a preventive measure in the early and mild stages of the disease should be weighed against a higher mortality rate among such patients in later years, from complications such as acute cholecystitis and common duct stone. In a population of increasing longevity, this problem is assuming a place of greater importance.

The effectiveness of any plan of treatment is enhanced when an early correct diagnosis is made. The classic case of acute cholecystitis eventually offers few difficulties in diagnosis. However, the onset may present a confusing picture, since there may be only epigastric pain and sometimes substernal distress associated with shortness of breath. This may so simulate a cardiac disturbance that a diagnosis of gallbladder disease may be overlooked until a mass develops in the right upper quadrant. In our experience, one of the common causes of delay in seeking surgical consultation is the frequency of ascribing the above symptoms to an "acute cardiac episode." Early in the attack a mass may not be palpable, the signs of intra-abdominal inflammation minimal, and the entire symptomatology due to referred pain, resulting from the distention of the cystic duct, usually by a calculus. As a result of the cystic duct obstruction, the chemical composition of the liquid contents of the gallbladder is rapidly changed. This concentrated mixture tends to produce a chemical rather than a bacterial irritation of the gallbladder mucosa, which results in typical marked distention and acute pathologic changes of its wall. The onset of localized tenderness, rigidity, and acute distress in the right upper quadrant may be delayed until these local changes have progressed to the point that the overlying peritoneum is irritated by the distended gallbladder.

It is not uncommon for the clinical syndrome of acute cholecystitis to be complicated by an associated acute pancreatitis. Since determinations of the blood amylase level have been made routinely in all acute conditions of the upper abdomen, it is surprising how frequently the presence of acute pancreatitis is discovered. This is valuable information, for the results are better if surgery is delayed until the acute pancreatitis has subsided and the patient reevaluated.

The present concepts of management of acute cholecystitis are based largely upon studies of the local pathologic process. For many years, it was assumed that bacterial invasion was invariably associated with acute cholecystitis, and the policy of "watchful waiting" was evolved from this theory. The danger of spreading the localized infection and the technical difficulties involved in surgical intervention were emphasized. Since, in the majority of cases, the acute signs and symptoms subsided under this conservative regimen and surgery was not often recommended during the acute attack, the physician did not consider hospitalization necessary. Although hospitalization was urged if there was even a suggestion of appendicitis, it was common practice to withhold this recommendation from the patient with acute cholecystitis except in the critically ill. Many patients who had been treated in the hospital during their acute episode were discharged with instructions to return in several months for cholecystec-

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tomy. It was thought that the patient would then be in better condition, the surgical procedure would be far easier and safer, and that fewer two-stage operations would be necessary.

While infection may play a major role from the beginning in some cases of acute cholecystitis, it is probable that in the majority of cases the infection is a process superimposed on already damaged tissue. In recent years, it has been demonstrated by smear or culture that the pus-like contents of even a highly inflamed gallbladder may contain no bacteria, but are, in reality, a concentrated chemical solution of cholesterol, calcium carbonate, etc. An attack is almost always initiated by obstruction of the cystic duct, following which the gallbladder apparently acts as a dialyzing membrane filled with hypertonic solution which draws fluids into it.[1] This theory is further substantiated by the greatly increased pressure within the gallbladder, which we measured in 5 cases of acute cholecystitis and found to vary between 23 and 56 cm. of water, whereas the pressure within the normal gallbladder is approximately 10 cm. of water. The highest pressure was found in a patient eight days after the onset. The wisdom of relieving this abnormal pressure before gangrene or perforation occurs is obvious.

Those favoring early operation[2,3] point out that while the majority of patients recover promptly on conservative treatment, it is never possible for the clinician to predict the response of any given patient. Furthermore, they say that the inflammatory process is often much more severe than the physical signs and laboratory data would indicate. For these reasons, the patient with acute cholecystitis should always be hospitalized just as in appendicitis.

It should be pointed out that the most earnest advocates of early surgery probably do not operate upon the patient with acute cholecystitis as early as the patient with acute appendicitis. Actually, a combination of the two schools of thought is desirable, since each patient is an individual surgical problem. The strongest argument in favor of early operation has been the fact that a substantially lower mortality rate is reported than when the traditional conservative policy is practiced. They have shown a lower incidence of complications, and hence a shorter period of hospitalization.

Details of Management

Once the diagnosis of acute cholecystitis has been made, the patient should be hospitalized immediately, regardless of how minor the signs and symptoms may be. This should not be interpreted as meaning that operation must be performed immediately, as in acute appendicitis. Only in the hospital, however, is it possible to follow accurately the often unpredictable clinical course of these patients, so that the optimum time for operation can be determined. Since the greatest advances in surgery in recent years have been in the details of preoperative and postoperative care, it is apparent that the earlier these principles are applied, the less risk there will be to the patient.

An estimation is made of the extent and severity of the inflammatory processes involving the gallbladder. In addition to the routine laboratory work, determinations are made of blood sugar, urea nitrogen, prothrombin, chlorides, plasma proteins, and blood amylase to establish a base line for chemical balance. These tests obviously are more essential in the severe cases; however, a blood amylase is taken routinely to eliminate the possibility of associated pancreatitis.

The restoration of the fluid balance is begun with the intravenous administration of 10 per cent glucose and distilled water, the amount being determined by the clinical condition of the patient as well as by the laboratory findings. Constant gastric suction is instituted if there has been vomiting or evidence of distention. Usually this routine is followed in any patient showing evidence of intra-abdominal inflammation.

The use of penicillin and sulfa drugs is probably of little value in the early cases of acute cholecystitis. Recently it has been shown that occlusion of the cystic duct, which is the most important single factor in this disease, will prevent the concentration of these drugs within the gallbladder. Since the early pathologic process is usually on a chemical rather than a bacterial basis,[1] as mentioned before, recently we have given up using chemotherapy or antibiotics in our cases of acute cholecystitis.

Temperature, pulse, and respiration are recorded every two hours, and a white blood cell and differential count is made every three to eight hours. Frequent evaluation of the clinical signs and symptoms of the patient is also made. It has been found useful for subsequent comparisons to outline the limits of the right upper quadrant mass, if one exists, on the skin of the patient. The vital capacity is determined upon admission and several times daily as additional evidence of an advancing or subsiding process. The vital capacity tends to decrease markedly if the gallbladder continues to distend and the disease progresses. Indications of a progressive pathologic process are (1) an increase in temperature, pulse, and respiratory rate, (2) a well defined mass in the right upper quadrant, increasing in size, (3) an increasing white blood cell count and an increase of the ratio of polymorphonuclear leukocytes, (4) a decreasing vital capacity, and (5) persistent or increasing signs of pain and tenderness in the right upper quadrant. Incipient gangrene with probable perforation should be considered if the while cell count is elevated to 20,000 or above.

The optimum time for operation depends entirely upon the general condition of the patient and the progression of the pathologic process as determined by the clinical signs and symptoms, as well as by laboratory findings. Certainly routine management is unsatisfactory, and each patient should be evaluated and managed individually.

In our experience, the greater number of patients with acute cholecystitis have had their attack longer than twenty-four hours before entering the hospital (average four days), so that it would usually be impossible to carry out surgery within forty-eight hours of the onset of the acute attack, as has been recommended.[6] We have observed that about 3 patients out of 4 with acute cholecystitis will respond to the usual conservative measures, and operation is performed within a week after admission (average, ten days from onset of symptoms); however, it should be remembered that about 25 per cent of the patients, or 1 in 4, fail to improve with conservative and supportive measures, and operation must be performed in almost every case after fluid balance is established, within thirty-six to forty-eight hours after admission. About 5 per cent of the patients, or 1 in 20, show rapidly increasing signs and symptoms which raise the question of free perforation and make surgery mandatory as soon as operative preparation can be completed. If the patient has been operated upon previously, there is more danger of a free perforation because of the likelihood of fixation of the omentum elsewhere, which prevents its walling off the gallbladder.

We have reached five general conclusions in determining the optimum time for operation:

1. We are in accord with those who favor early operation in "good risk" patients, although we have had little opportunity to operate upon many patients within twenty-four to forty-eight hours after the onset of their acute cholecystitis.

2. Operation soon after hospitalization is imperative if there are signs of generalized peritonitis, implying a free perforation of the gallbladder.

3. Operation is advisable if the signs and symptoms do not improve within twenty-four to thirty-six hours after admission into the hospital. A leukocytosis of 20,000 or above is indicative of impending gangrene and an indication for surgery.

4. Surgery should be carried out if the patient doing well on conservative management has a recurrence of pain requiring additional sedation or has a higher temperature and leukocytosis, a flareup of the signs of inflammation, or an increase in the size of the mass in the right upper quadrant develop.

5. Finally, the mortality rate will be lowered when operation is performed, at any hour of the day or night, immediately after the decision is reached that a patient, in good fluid balance, is getting worse.

Surgical intervention should be delayed under the following conditions:

1. It is desirable to delay operation in those patients seen late in the course of their disease, who already have decreasing signs and symptoms. We believe, however, that after several days these patients can be safely subjected to surgery and should not be sent home without operation to run the risk of a recurrent attack.

2. Operation is delayed or not recommended in the elderly or "poor risk" patients who respond promptly to conservative measures. However, with the increase in life expectancy, the physician and surgeon must accept the responsibility of treating elderly patients. Although the mortality rate is usually higher for any type of surgical procedure in patients above middle age, there is no contraindication to surgical intervention in acute cholecystitis in the older age group. The physician should carefully consider the advantages of surgery early in the course of the disease, when the patient is a better risk and free of complications.

3. It is wiser to delay surgery if the patient has acute pancreatitis in addition to acute cholecystitis.

Technical Considerations

The type and extent of the surgical procedure usually cannot be determined until the peritoneal cavity is opened and the local pathologic process involving the gallbladder is evaluated. The general condition of the patient, the presence of an abscess, and the technical difficulties encountered in isolating the gallbladder, especially in the region of the ampulla and cystic duct, determine the type and the extent of the operation. Although cholecystectomy is the operation of choice, it may be better judgment to decompress the gallbladder, remove the calculi, and institute drainage by cholecystostomy. This principle is followed in "poor risk" patients in whom minimal surgery is desirable, when an abscess is encountered, or when technical difficulties make cholecystectomy hazardous. The most important procedure in cholecystostomy is the removing of all calculi possible, especially any occluding the cystic duct, in order to assure free bile drainage. A large drainage tube should be used.

Partial cholecystectomy is a valuable procedure in many cases and deserves more widespread use as a substitute for cholecystectomy. After dividing the wall of the gallbladder from the fundus down to the region of the ampulla, the excess is trimmed away on either side, leaving that portion adjacent to the liver undisturbed. Bleeding points along the edematous thick cuff of retained gallbladder wall are individually ligated. No effort is made to isolate the cystic vessels or duct. Any calculi obstructing the cystic duct are removed, and an attempt made to anchor a small catheter into the cystic duct. Penrose drains are inserted to assure free drainage. It is unnecessary to attempt to destroy the remaining gallbladder mucosa by cauterization.

In the majority of cases, cholecystectomy can be performed without troublesome bleeding if advantage is taken of the edematous subserosal layer of the acute gallbladder. After the serosa has been incised, a definite cleavage plane can usually be found, thereby simplifying the procedure. It cannot be denied, however, that the greatly distended and acutely inflamed gallbladder increases the technical difficulties and enhances the dangers associated with cholecystectomy. In the first place, the acute gallbladder may be torn away from the liver bed if too much traction is applied to it before an inci-

sion is made through the serosa to develop a subsequent cuff of tissue for closure. If such a tear occurs, a bleeding, raw liver surface is exposed, which hinders the subsequent stages of the operation and makes a satisfactory closure of the liver bed almost impossible. Secondly, there is a danger of injury to the common duct if clamps are applied to the region of the distended ampulla of the gallbladder before it has been isolated from the adjacent structures by finger or blunt gauze dissection. Thirdly, it should be remembered that the common duct, the cystic duct, and vessels including the right hepatic artery may be drawn up into an unusual position as a result of the inflammatory process. Any of these structures may be injured if clamps are blindly applied to the region where the cystic duct and vessels are ordinarily found. The majority of accidents to the common duct and other structures usually occur in patients in whom there is an excessive amount of bleeding, necessitating the repeated application of hemostatic clamps for its control. Blind clamping for bleeding points deep in the operative field should be avoided. The bleeding should first be controlled by compressing the hepatic artery in the hepatoduodenal ligament between the index finger in the foramen of Winslow posteriorly, and the thumb anteriorly. After the excessive blood in the operative field has been removed by suction, the digital compression is released sufficiently to locate the bleeding point for the accurate application of a hemostat. The classic retrograde cholecystectomy should be attempted, therefore, only when the structures about the cystic duct can be readily identified.

It is usually safer to evacuate the contents of a large acute gallbladder and remove it from the fundus downward in order to identify and ligate the artery and duct more easily and safely. Dissection may be facilitated if a gauze sponge or the left index finger of the surgeon is introduced into the lumen of the gallbladder to provide counter-resistance as the gallbladder is removed along the edematous cleavage plane. The gallbladder bed is closed with interrupted sutures to assure a dry field as the dissection is carried downward to the cystic duct. An attempt is made to isolate and ligate the cystic vessels and duct individually. Silk (000) suture material on French needles is used routinely. Drainage is instituted by means of Penrose tubing inserted through a stab wound. In recent months we have injected the lower six intercostal nerves on the right side with nupercaine in peanut oil at the completion of the operation. We have been impressed with the early postoperative comfort this has effected in the majority of cases and the appreciable decrease in the incidence of pulmonary complications.

The foregoing principles of management of acute cholecystitis have been found invaluable as a working guide to young surgeons. During the past year on a teaching service, the over-all mortality for operations performed for chronic as well as acute cholecystitis, but exclusive of carcinoma, was 1.9 per cent. Over 60 per cent of these patients were operated upon by the resident staff.

Conclusion

Immediate hospitalization of the patient is imperative when a diagnosis of acute cholecystitis is made, because it is impossible to predict the subsequent course of the disease. The time of operation is determined by the frequent evaluation of the clinical and laboratory findings. In general, prompt operation is imperative in the face of unfavorable developments in clinical and laboratory findings; cholecystectomy may be delayed in the presence of subsiding signs and performed later during the same hospital admission.

Individual consideration of each case of acute cholecystitis and assiduous attention given to the details of management will reward the physician with a lowered morbidity and mortality rate.

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STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES TO HOLD EXAMINATIONS

The next examination of the Wisconsin State Board of Examiners in the Basic Sciences will be held at the Plankinton House, Milwaukee, on June 5. The last filing date is May 29.

The following examination will be held in the Assembly Chamber, State Capitol, Madison, on September 25. The last filing date is September 18.

Anesthesia and Liver Function*

By FREDERICK J. POHLE, M. D.
Madison

F. J. POHLE

Doctor Pohle, a former associate professor of internal medicine at the University of Wisconsin Medical School, died in Madison on November 26. The doctor was a graduate of the University of Michigan Medical School and had joined the staff of the University of Wisconsin in 1938. During World War II he served with the Army Medical Corps for four years, being discharged in 1945 with the rank of lieutenant colonel.

THE effects of anesthetics on hepatic function have been extensively studied in laboratory animals. Investigation of the hepatotoxic properties of these agents in human beings has been limited to study of material obtained at autopsy and to a comparatively few studies of liver function made before and after operation. Studies of the latter type have been reported by Boyce and McFetridge[1] and Schmidt, Unruh, and Chesky,[2] employing the oral hippuric acid test; by Engstrand and Friberg,[3] with the intravenous hippuric acid test; and by Coleman[4] and Cantarow, Gartman, and Ricchiuti,[5] using the bromsulfalein retention test. There is general agreement among these studies that alterations in hepatic function are not uncommon during the postoperative period.

During the past decade there has been a revival of interest in the study of disorders of the liver, and many new so-called hepatic function tests have been introduced. Emphasis has been placed upon an increase in sensitivity of the methods in order to detect latent or "subclinical" liver damage. There is no universal test to measure the multiple functions of this organ, and most workers agree that single tests are likely to prove misleading. The consensus is that the simultaneous performance of several procedures affords a more accurate estimation of the functional state of the liver. The purpose of the present clinical investigation was to observe the effects of various commonly employed anesthetics administered for major surgical procedures on a battery of the more modern hepatic function tests.

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

This study was supported in part by the Research Committee of the Graduate School from funds supplied by the Wisconsin Alumni Research Foundation.

Methods

One hundred and fifty-four patients were studied before and after operation. The anesthetics administered were as follows: chloroform, 65 cases; ether, 30 cases; cyclopropane, 20 cases; nupercaine spinal, 9 cases; pentothal, 9 cases; and avertin, 21 cases. This distribution as well as the average duration of anesthesia is shown in table 1. Extensive studies, directed by Waters, designed to revaluate the effects of chloroform in man account for the larger number anesthetized with this drug. A detailed analysis of the data on liver function for these 65 cases is included in a series of papers to be reported elsewhere.[6]

TABLE 1.—*Types of Anesthetics*

	Number of Cases	Average Duration in minutes
Chloroform	65	120
Ether	30	135
Cyclopropane	20	102
Spinal	9	80
Pentothal	9	87
Avertin	21	158
Total	154	

All of the individuals in the present study were adults. The average age was 51 years. The six groups anesthetized with different agents were similar as to age, sex, nutrition, extent of the operation, and preoperative and postoperative care. In general, the nutrition was not satisfactory, since a majority of the patients suffered from malignant disease. In general, the operations were extensive and included a variety of intra-abdominal, intrapleural, and intracranial procedures. All of the anesthetizations were performed by experienced members of the department of anesthesiology of the University of Wisconsin Medical School. Regardless of the agent used or its method of administration, the maintenance of a free airway was considered essential. Supplementary oxygen was usually given.

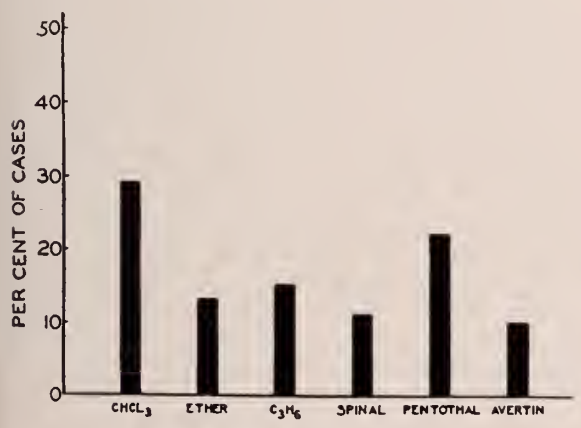
The tests of hepatic function routinely employed were the icterus index, the cephalin cholesterol flocculation test of Hanger,[7] the bromsulfalein test, the Quick prothrombin time,[8] and the thymol turbidity reaction as described by Maclagan.[9] These methods were selected because of their simplicity, sensitivity, and adaptability to a study requiring repeated observations. In our experience such a composite study has quite regularly supplied information which correlated rather well with the histologic picture. Data obtained with other functional

tests were incomplete and are omitted. The battery of tests was performed on all patients prior to operation, and serial observations were made three times per week for an average period of two weeks postoperatively.

Results

The data collected were massive. Each of the five tests used to detect a disturbance of liver function was performed not less than seven hundred times. It is not possible in this brief presentation to present all of the data obtained on each of the patients. Laboratory evidence of a transitory decrease in hepatic function was observed in 82 patients, or 53 per cent of the total series of 154 individuals. The pattern in the subjects demonstrating abnormal changes in one or more of the tests was similar in each case. These changes occurred within the first few days after the anesthesia, often the first, and with few exceptions returned to normal by the seventh to tenth postoperative day. Although these transitory changes were often rather marked at their height, jaundice in 9 subjects was the sole clinical evidence of disturbed hepatic function.

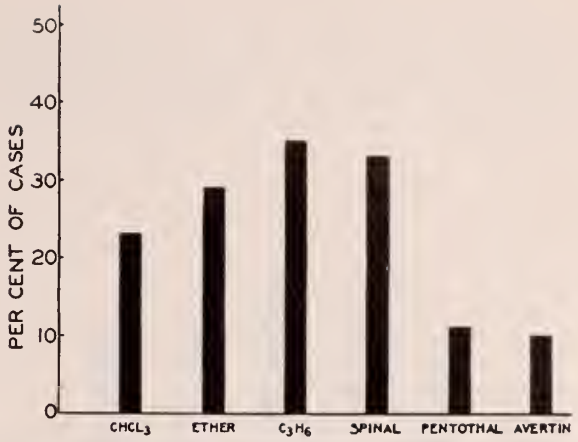
The data were reviewed in an effort to compare the effects of each of the several anesthetic drugs on each of the laboratory tests employed. Figure 1 presents in graphic form the percentage of patients in each of the six groups who showed a significant rise in the icterus index during the postoperative period. A value of 10 units or more was considered abnormal. The figure shows that such elevations occurred in from 10 to 29 per cent of the cases. Usually the degree of jaundice was slight.



ICTERUS INDEX. PER CENT OF CASES WITH ABNORMAL POSTOPERATIVE VALUES

Figure 1

The percentage of patients in each of the six groups in whom a positive reaction to Hanger's test developed postoperatively is shown in figure 2. A flocculation reaction of 2 plus or more was considered abnormal. Altered hepatic function as measured by this test occurred in about one-third of the

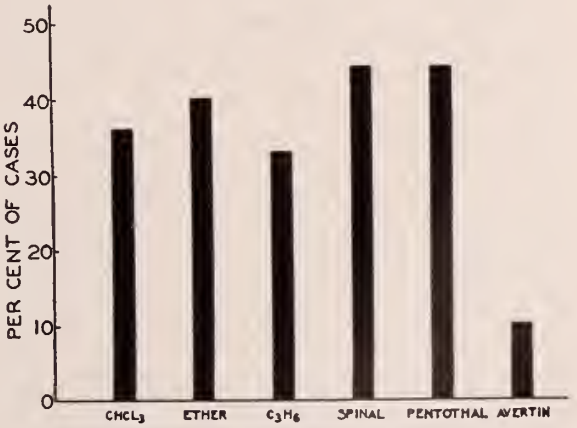


HANGER'S TEST. PER CENT OF CASES WITH ABNORMAL POSTOPERATIVE VALUES

Figure 2

patients who received inhalation or spinal anesthesia and were less frequent after avertin and pentothal.

Figure 3 presents in a similar manner the percentage of individuals in each group receiving a different anesthetic who suffered hepatic dysfunction as indicated by the retention of bromsulfalein. The reading was made twenty minutes after the intravenous administration of 2 mg. of the dye per kilogram of body weight. Values of 5 per cent or more were considered abnormal. The figure shows that approximately one-third of the patients retained abnormal amounts of the dye with all the agents except avertin.

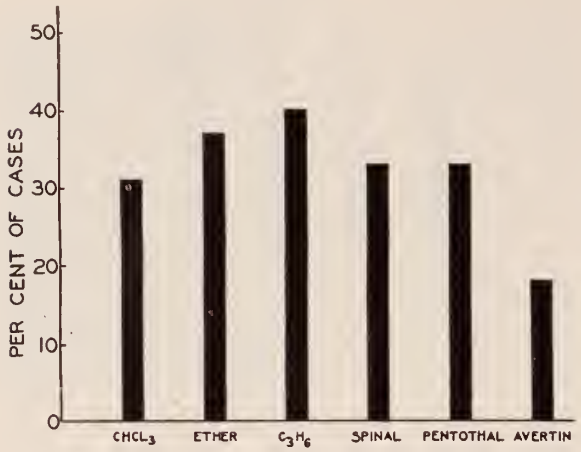


BROMSULPHALEIN. PER CENT OF CASES WITH ABNORMAL POSTOPERATIVE VALUES

Figure 3

Figure 4 illustrates the frequency of a decrease in plasma prothrombin in each of the six groups postoperatively. Although one is reluctant to define an inflexible limit of normal for a test which admittedly is only a crude index, a value of 70 per cent or below was considered abnormal in order

to facilitate comparison of the several groups. As with Hanger's test and the bromsulfalein test, approximately one-third of the patients demonstrated a significant reduction in plasma prothrombin during the postoperative period.



PROTHROMBIN. PER CENT OF CASES WITH ABNORMAL POSTOPERATIVE VALUES

Figure 4

The thymol turbidity reaction was not helpful in the detection of latent hepatic dysfunction in the present study. Only 2 patients who received chloroform and 2 who were anesthetized with ether showed abnormal values postoperatively in spite of the fact that along with others[10] we have lowered the upper limits of normal for this test from 4 to 2 units. Values of several units have been frequently observed in conditions such as infectious hepatitis. The reason for the discrepancy is not clear.

Rarely were all of the tests abnormal in the same individual. Occasionally only one of the precedures suggested a liver disturbance. Usually, however, there was a parellelism between the results of Hanger's test, the bromsulfalein test, and the prothrombin determination. The rigid limits of normality defined earlier for each of the tests enables comparison of the six groups in another manner. The percentage of patients in each group who showed a variation from normal in one or more of the tests postoperatively is shown in table 2. This

TABLE 2.—*Incidence of Abnormal Hepatic Function after Operation*

Anesthetic	Per Cent of Cases
Chloroform	52
Ether	60
Cyclopropane	60
Spinal	66
Pentothal	55
Avertin	33

analysis indicates that some degree of impairment of hepatic function occurred in from 52 to 66 per cent of the patients who received chloroform, ether, cyclopropane spinal, or pentothal anesthesia. Disturbances of function were less frequent following avertin (33 per cent). Since our criteria of normality were rather severe, it may well be that all of these values are somewhat high. A conservative conclusion from these data is that some alteration of hepatic function occurs in approximately 50 per cent of patients subjected to extensive operative procedures regardless of the type of anesthetic administered.

There were no deaths during operation in the total series. Eight patients died several days following operation, and 2 infants delivered by cesarean section died at fourteen and twenty hours. Autopsies were performed in 9 of the fatal cases and revealed damage to the hepatic parenchyma in 2 instances. One of these subjects had received chloroform and the other avertin. The liver in each showed a minimal central necrosis.

Discussion

It is difficult and probably impossible to determine from a clinical study of this type exactly how much of the impaired function is due to a direct hepatotoxic action of the anesthetic agent. Indeed, the rather uniform frequency of altered function in the six groups suggests that some other factor or factors may play a more important role than the drug itself. It has been suggested that some of these factors are the extent of the operation, hemorrhage, shock, the nutritional state of the patient, and the hypoxia which occurs all too frequently during and after operation. In the present investigation a real attempt was made to insure adequate oxygenation of the blood and tissues and thus to control one of the most important factors.[11]

The consensus now is that the presence of normal glycogen stores and adequate available protein, including the lipotropic agents, as well as the absence of excessive deposition of fat in the liver, are fundamental in the preservation of normal function when this organ is insulted. Control of the nutrition of patients on whom operations are necessary is difficult. In the majority of individuals in the present study the nutrition was substandard. These subjects were therefore probably more susceptible to disturbances of hepatic function than the normal. This does not detract from the significance of the foregoing data, however, since this is the usual type of patient who presents himself to the surgeon and the anesthetist for the more serious and complicated operative procedures.

Summary and Conclusion

1. A battery of hepatic function tests was performed before and at intervals after operation in 154 individuals. The patients were anesthetized with one of six agents as follows: chloroform, ether, cyclopropane, nupercaine spinal, pentothal, or avertin.

2. The duration of anesthesia was long and the operative procedures extensive. The majority of the patients were not well nourished.

3. Impairment of hepatic function following operation was observed in approximately 50 per cent of the cases irrespective of which of the six anesthetics had been administered. The alterations in function were transitory and were rarely suspected clinically.

4. Many factors besides the anesthetic agent contribute to the decrease in hepatic function frequently observed postoperatively. The importance of the nutritional state and the avoidance of oxygen lack are emphasized.

5. The present observations suggest that the deleterious effects of chloroform on the liver have been overemphasized in the past. It is our considered opinion, however, that the adverse cardiac effects which frequently occur do not warrant a general revival of the use of this agent in clinical practice.

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AMERICAN HEART ASSOCIATION RECEIVES GIFT OF $1,500,000

Presentation of a check for approximately $1,500,000 was made to the American Heart Association by Mr. Ralph Edwards at a testimonial luncheon held in Chicago on April 14. The check represented the total of public contributions made to the Association during the "Walking Man" contest on the "Truth or Consequences" radio program.

The luncheon, arranged by members of the American Heart Association, honored Mr. Edwards and the sponsor of the program, the Proctor and Gamble Company, for their cooperation in the 1948 campaign to combat diseases of the heart and circulation. The funds will be utilized for the Association's continuing program of scientific research, education, and community service in cardiovascular disease.

Speakers included Oscar R. Ewing, federal security administrator, and Dr. A. R. Barnes, president of the American Heart Association. Mr. S. DeWitt Clough, chairman of the board, Abbott Laboratories, served as chairman.

The Treatment of Carcinoma of the Cervix*

By ROLAND S. CRON, M. D.
Milwaukee

R. S. CRON

Doctor Cron, head of the department of obstetrics and gynecology at Marquette University School of Medicine, graduated from the University of Michigan Medical School in 1917. Following his graduation, he was assistant professor of obstetrics and gynecology at the University of Michigan Medical School for two years. At present he also serves on the staffs of Milwaukee, Columbia, and Milwaukee County hospitals.

THE treatment of carcinoma of the uterine cervix will be presented from three standpoints: (1) prevention, (2) cure, and (3) palliative relief. It is doubtful whether there is any disease in which prevention of the development of a primary lesion is more important than in this one. Most illnesses are self limited, and the majority of the remaining ones have been and are being successfully combatted with more or less specific therapy. Education of the public to undergo frequent periodic complete examinations and to seek competent medical advice when first symptoms appear is imperative. Women should be made to realize that the surest way to prevent the development of cervical cancer is to submit to an examination which is complete only when the cervix has been visualized and, if necessary, biopsied.

Further prevention consists in restoring the diseased cervix to as normal a state as possible. This can be accomplished by cauterization of the eroded or infected cervix with the fine-pointed electric cautery. Escharotics such as silver nitrate and phenol are not recommended, while conization of the badly eroded or infected cervix is an excellent procedure. This can be done with the high frequency cutting current or by surgical extirpation. The latter procedure is best carried out according to the technic described by Sturmdorf. It is often a sanguinous and formidable procedure and therefore is not recommended as a routine method of treatment. Repair of the lacerated everted cervix is frequently in order. The tissue removed by any of these procedures should be submitted to a pathologist for microscopic study. Electrocoagulation of the cervix damages the tissues so badly that microscopic study is impossible. Furthermore, coagulation may often produce troublesome stenosis of the cervical canal. Repeated cauterization of the cystic cervix is not good practice. Puncture of the cysts does not cure the condition. Instead, additional cysts develop—the result of the closure of the ducts of compound racemose glands by scar tissue. Conization will remove the cervical glands and prevent further cystic change. The cystically degenerated cervix rarely becomes malignant.

Cervical cancer is prevented when that organ is removed either by means of a total hysterectomy or by amputation. Some authors believe that the total hysterectomy results in shortening of the vagina, higher morbidity, and occasional fistula formation. Even so, whenever the cervix is diseased and a hysterectomy is indicated, if the total operation can be performed safely, such a procedure should be undertaken. If an unhealthy cervix is left in place it should be treated postoperatively. Cancer of the cervix cannot develop in the extirpated cervix. Very rarely has it appeared in a healthy organ. In thirty years of active obstetric and gynecologic practice the author has not observed a carcinoma develop in the cervix of any patient for whose care he has been responsible. It is his contention that squamous cell carcinoma, which makes up at least 95 per cent of cervical cancer, rarely appears in a healthy cervix.

One of the most serious problems confronting the patient with carcinoma is the interval or lag from the appearance of the first symptoms to the initiation of proper treatment. Much can be done to prevent the advancement of the early cancer to a late one if better cooperation could be obtained from the practicing physician. Evidence has been accumulated to show that by education of the public the interval from the appearance of the first symptoms of cervical cancer to consultation with a physician has been definitely reduced. On the other hand, the interval from the consultation with a physician until proper treatment has been instituted has not decreased. It is, therefore, most important that the physician examine his patient at the time of the first visit. Furthermore, this examination should be complete to the point of visual inspection of the cervix, and biopsy of all suspicious lesions. Then if carcinoma is present, proper treatment should be initiated *immediately.*

Cure

Most of the patients treated for cervical carcinoma at Columbia, Milwaukee, and Milwaukee County General hospitals were hospitalized during the initial stages of the therapy. X-ray therapy was given first in most instances in order to combat

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

parametrial thickening, for if this proceeds unchecked it will be fatal. Further advantages of this regimen of treatment are that x-ray aids in cleaning up infection and reduces the size of the tumor, thereby making the insertion of radium easier and more effective. Usually four, and occasionally five or six, ports were used delivering to each field 1,200 to 2,000/r for a total of from 2,400 to 6,000/r. This fractionated or divided dose method delivers to the parametrium a maximum dose with fewer secondary reactions. We have had no experience with the vaginal cone although frequently a perineal field has been used.

Earlier in our treatment of cervical cancer, radium element was applied prior to x-ray therapy. Later, about one-half of the planned dose of x-ray was given and then the radium introduced. Since about 1940 radium has been applied one to two weeks following the last x-ray treatment. The average dose applied intracavitory, over the face of the cervix and into the lateral, anterior, and posterior fornices of the vagina has totalled between 3,600 and 6,000 mg. hours. The radium has been filtered with 1 mm. of platinum. In the past, 10 to 12½ mg. interstitial needles have also been used with apparently good results.

The radium patient should be individualized and there should be no fixed type of applicator used or amount of element administered. The amount of x-ray treatment delivered to the patient has depended upon the dose of radium applied to the cervix. When that dose has been high, the x-ray has been proportionately low. This, of course, accounts for the variation in both the radium and the x-ray dosage mentioned above. Whenever possible it has been our policy to concentrate the entire series of x-ray and radium treatments into a period not to exceed four to six weeks. It is our opinion that our end results have improved with this arrangement. Certainly it is a better practice than that once indulged in at one of our institutions where treatment covered a period of three months or more. There again and again the growth of the carinoma seemed to have been stimulated rather than retarded by treatment. The importance of *early* treatment cannot be overemphasized. The patient's future is decided by the treatment instituted and carried out by the physician or physicians first caring for her.

Mail order houses renting radium indiscriminately and advising by telephone or postman the type of treatment and dosage to be used for cancer have been a big factor in continuing the very unsatisfactory end results in the treatment of this disease. There are many patients with cervical carcinoma who have been treated most inadequately because some one of these institutions made it appear that all one needed to do was insert into the cervical canal or vault of the vagina a 50 or 100 mg. capsule of radium. Then by some magic the cancer is supposed to be cured. At times there is no gynecologic procedure more difficult to perform than the proper introduction or placing of radium. Since the patient with an early cervical carcinoma does not need the same dosage or type of application of radium as does the woman with a large cauliflower growth or a deep excavating ulcer, individualization in the treatment of this disease is most essential.

Proper screening of the radium, protection of the vagina, rectum, and bladder by means of well placed packing, and decompression of the bladder by catheterization must be practiced to prevent future radium reactions with possible fistula formation. All too frequently the physician who uses this mail order type of radium therapy fails to arrange for adequate x-ray therapy when, as a matter of fact, this type of treatment is most important.

It will be noted that an occasional microscopic or very early cervical lesion has been successfully removed by surgical extirpation. In most cases this lesion was found in the cervix following total panhysterectomy for some other uterine lesion. The practice of either total panhysterectomy or the radical Wertheim for cervical carcinoma is not here advocated. Equally good or even better results have been obtained by x-ray and radium therapy without the high risk of life, morbidity, and adjacent organ damage as is obtained by operative procedures. It is the writer's contention that there are so few operators capable of performing the radical operation that in the best interest of the carcinoma patient it is not the wisest practice to follow. Surgical extirpation of the uterus and adnexa following adequate x-ray and radium therapy has not improved the end results of this disease and so is not considered to be good practice by most authorities.

Palliative Relief

Not all patients with cervical carcinoma should be treated. Both x-ray and radium have frequently suffered disrepute because of so-called failure to cure advanced cancer. The patient with far advanced malignancy often cannot be benefited by treatment. Active bleeding and a foul discharge may be relieved by x-ray or radium treatment and occasionally regression of the disease occurs. Whenever possible, these two procedures should be reserved for use in the patient who may obtain beneficial results.

The relief of pain during the latter stages of advanced cancer should be accomplished as long as possible with the use of non-habit-forming drugs. For that reason a combination of aspirin and codeine is to be preferred over morphine. Use of vitamin B complex during the stage of active radiotherapy as well as later to control gastrointestinal distress should be mentioned. Excruciating pain may be relieved by intrathecal administration of alcohol and occasionally by chordotomy. Presacral neurectomy for the control of pain has not been effective in the advanced stages of pelvic cancer. Finally in the terminal weeks of the disease there is no objection to the liberal use of morphine.

One of the greatest difficulties experienced by the practicing physician in the care of the carcinoma

patient is the subsequent "follow-up." The profession appreciates that a patient is never considered cured until at least five to ten years have elapsed from the time of the original therapy. Therefore, carcinoma patients should be examined at regular intervals every three, four, or six months for at least five years. If any evidence of recurrence appears, further therapy should be administered. Even though patients are advised to return for these examinations a high percentage fail to do so. Many think it is unnecessary; others prefer to remain ignorant of their progress, while some are physically unable to do so.

As a result of the many problems relative to the treatment of cervical cancer, might it not be wise to arrange for these patients to be cared for by a team? Certainly the best results obtained thus far in America have been those in which an accomplished group of physicians have each in his own field directed the treatment and then relied upon some type of social service or lay personnel for the follow-up.

Between the years 1932 and 1942, 72 patients with cancer of the cervix were treated in one of two private hospitals. The technic used and x-ray and radium applied to these patients have been indicated elsewhere in this paper. A study of these 72 women showed that the malignancy may appear any time from the twenties on through the sixties. The ages varied from 29 to 66 years, with an average of 46 years. Squamous cell or epidermoid carcinoma was found in 60 cases, while adenocarcinoma was diagnosed in 12. Ten patients were found to have stump cancer. This is a very high percentage and is due in part to the fact that 3 patients had subtotal hysterectomies performed at other institutions for adenocarcinoma of the fundus. Undoubtedly the previous inadequate surgery resulted in an incomplete removal of all carcinomatous tissue.

Both grading and stage of the disease had a definite influence upon the end results. In 24 of the patients treated the lesions were considered to be stages I or II, which meant that the carcinoma was still confined to the cervix. Four of these patients died from generalized carcinomatosis. The other 6 patients, making 26 in all, who are alive and well had stage III lesions. There were 4 additional patients with stage III and IV who lived more than five years but eventually died from carcinomatosis. These 4 others who could not be traced have, from a statistical standpoint, been considered dead. There are then 26, or 36¼ per cent, of the 72 patients alive and well five to ten years following treatment. Grading of the tumors was not done on all lesions, but our impression is that in those patients who have survived there was a preponderance of grade II and III lesions over the higher grade IV. One of the living patients has a rectovaginal fistula and another experienced a resection of the lower sigmoid because of radiation stricture.

Summary

1. Prevention in the development of carcinoma of the cervix should be accomplished by (*a*) continued education of women to submit to periodic complete pelvic examinations and to seek *immediate* treatment for any evidence of dysfunction of their generative organs; (*b*) continued education of the profession to examine completely the female genitalia upon the initial visit of the patient and personally to institute curative treatment of all benign lesions of the cervix as early as possible.

2. When the diagnosis of carcinoma has been made, immediate deep x-ray therapy and radium treatment should be instituted. The patient's future depends upon the despatch with which this is accomplished.

3. A system of follow-up is essential. Patients should be re-examined at frequent intervals so that any recurrence of the carcinoma may be promptly treated.

4. The earlier the lesion and the lower the grade of the cancer, the higher the survival rate. There are living and well 26, or 36¼ per cent, of the 72 patients studied.

C. H. Crownhart, Secretary,
State Medical Society of Wisconsin,
917 Tenney Building,
Madison 3, Wisconsin

Date _____

Dear Mr. Crownhart:

Attached is a check for $4.00 to cover my registration for the Postgraduate Clinic to be held at _____. Please send my luncheon ticket to my address given below.

LA CROSSE, June 1
WAUSAU, June 2
MANITOWOC, June 3

Please PRINT

Name _____
Street _____
City _____

(MAKE CHECK PAYABLE TO: THE STATE MEDICAL SOCIETY OF WISCONSIN)

(SEE PAGE 491 FOR PROGRAM)

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Choice of a Digitalis Preparation

In the U.S.P. XIII, which appeared in mid-1947, as in the preceding U.S.P. XII, the unit of digitalis represents the same potency as 0.1 gm. of the U.S.P. Digitalis Reference Standard Powder, but this does not simplify things greatly for the practitioner because the leaves from which the reference powder was made were of such high potency that 1 U.S.P. XIII unit is actually equivalent to 1.25 cat units. Nor is cat unitage a guarantee of uniformity in preparations, the reasons for its fallibility being two: (*a*) There are many variables in the performance of the cat bioassay itself, so that 1 cat unit of one preparation does not of necessity mean the same thing as 1 cat unit of another preparation; and (*b*) Gold (1945), in summarizing the work of his group through a number of years, showed that cat unit potency cannot be directly translated into clinical potency, for it was found that in a group of digitalis preparations with the same strength in cat units there was a ten-fold range in potency in human subjects. Now the human assay method, as devised by the group around Cattell and Gold at Cornell, is certainly the best method at present available, but the findings have not as yet been completely confirmed and have not been translated into terms of practicability for the general practitioner, *i.e.*, manufacturers have not made available preparations of digitalis leaf standardized in terms of potency in man. It would therefore seem that the practitioner today is best advised to follow one of two courses: either (*a*) to use a preparation of digitalis leaf obtained from one firm of manufacturers and employed by him in a routine fashion consistently with his experience of what he can accomplish with that leaf preparation; or (*b*) to use one of the newer crystalline glycosides obtained from digitalis that do not have to be bioassayed because they are pure chemical substances. The three such preparations available are: (*a*) lanatoside C, obtained from *Digitalis lanata;* (*b*) digoxin, also obtained from *D. lanata;* and (*c*) digitoxin, obtained from *D. purpurea,* the older and more familiar form of fox glove which comprises the official U.S.P. leaf.

A great deal of clinical work has been done in comparing the above three agents, all of which are acceptable and valuable drugs with which to digitalize the patient. In my opinion, which is of course merely an arm-chair reflection of a careful study of the work of those who have competently passed upon the matter at the bedside, these studies have shown that digitoxin is the most suitable agent of the three for the rapid accomplishment and satisfactory maintenance of digitalization through the use of a preparation by mouth. The advantages of digitoxin over the other two agents are that it is practically 100 per cent absorbed from the gastro-intestinal tract; its local irritant action in the tract is so low that a large proportion of the total amount required for full digitalization may be given in an initial single dose without causing gastro-intestinal upset; the onset of action is sufficiently rapid to meet the indications in practically all cases (though admittedly not quite as rapid as that of either lanatoside C or digoxin); and the prolonged duration of its action permits maintenance of the digitalized state more easily with it than with either of the two glycosidal preparations.

But another digitalis preparation is required by the practitioner, namely, a drug for intravenous administration when the rare case is encountered in which more rapid digitalization seems to be required than can be accomplished by the use of either the leaf or digitoxin by mouth. To be sure, under such circumstances digitoxin may be given intravenously but digitalization will be accomplished no more rapidly than had the drug been given by mouth for, as previously stated, this glycoside is practically 100 per cent absorbed from the intestine. Therefore it seems only natural to turn to the agent that experience has shown to be perhaps just a little more rapid in its action than any of the others, namely ouabain.

Finally, there is a situation in which one may have to go outside this group of three preparations —digitalis leaf, digitoxin, and ouabain—for an acceptable agent, namely instances in which congestive vomiting is very severe in the beginning and there is some reason for not digitalizing the patient by the intravenous method. In such circumstances one of the older injectable preparations, which are mixtures of glycosides from the *D. purpurea* leaf—digalin, digifoline, digitan—may be given intramuscularly in dosage recommended on the ampule, for the pure digitalis glycosides are much too irritant for subcutaneous injection and even their intramuscular injection may leave painful and tender areas.

Summarizing all of the above, it seems to me that the practitioner would do well in the present state of our knowledge to employ digitalis as follows: (1) to use digitoxin as his routine digitalizing drug; (2) to use digitalis leaf as his second drug to fall back upon in one or other of the following circumstances: (*a*) if the economics of the situation are of importance since digitoxin is more expensive

(Continued on page 532)

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

GORTON RITCHIE

Doctor Ritchie graduated from the University of Pennsylvania School of Medicine in 1927. He has served on the faculty of the University of Wisconsin Medical School and the Marquette University Dental School and as pathologist at St. Luke's and St. Mary's hospitals, Racine. He is a diplomate of the American Board of Pathology and is director of laboratories at Columbia and Milwaukee Children's hospitals, Milwaukee.

Prenatal Rh Testing

In any perusal of present day literature one may find many articles dealing with various aspects of the Rh factor and the academic or practical problems related thereto. These publications deal almost entirely with special segments of the subject, and are couched in terms almost incomprehensible to anyone but a serologist or geneticist. It is difficult to find a guide outlining simply and directly the management of pregnancy with relation to the Rh factor.

The following procedures are recommended as a practical means of detecting and handling cases of Rh-sensitization. Each step in the series depends to a large extent upon the result of the preceding step.

1. Have the prospective mother Rh-tested on her first visit to the office.
   a. If she is Rh-positive, no further tests are necessary.
   b. If she is Rh-negative,
2. Have the husband Rh-tested.
   a. If he is Rh-negative, no further tests are necessary.
   b. If he is Rh-positive,
3. Have anti-Rh determinations performed on the mother's serum at the end of the sixth month.
   a. If the mother is a primipara and has no Rh-antibodies in her serum, no further tests are necessary.
   b. If the mother is a multipara and has no Rh-antibodies in her serum, the probabilities are that sensitization has not occurred. However, another testing should be performed within a few days of the expected date of confinement to pick up cases in which the Rh-antibodies can not be detected earlier. If this last examination is negative, it is not likely that erythroblastosis fetalis will develop in the infant.
   c. If the sixth month test is positive, the titer of Rh-antibodies should be determined. A repeat titration should also be performed at the end of the eighth month. If the titer at this time shows an increase, consideration should be given to the advisability of terminating the pregnancy.
4. Existence of maternal sensitization to the Rh agglutinogen
   a. Will not affect an Rh-negative fetus, but
   b. Usually affects those who are Rh-positive, and may be manifested either as
      (1) Hemolytic anemia,
      (2) Icterus gravis, or
      (3) Hydrops fetalis.
5. Rapid diagnosis of the type of erythroblastosis is contingent upon
   a. Early postnatal hemoglobin determinations and erythrocyte counts on the infant's blood, and
   b. Anti-Rh determinations on the cord blood.

To obtain greatest cooperation in securing these examinations the laboratory should be alerted by the obstetrician before the infant's birth, or at least immediately thereafter, *and the proper orders written.*

6. Treatment
   a. The treatment of the hemolytic anemia type usually involves one or more transfusions of Rh-negative blood. This is safely given on the basis of 10 cc. per pound of body weight and repeated as often as necessary to maintain a level of 10 gm. of hemoglobin per hundred cubic centimeters and 3 million erythrocytes per cubic millimeter.
   b. The treatment of the icterus gravis type has in general been less successful, but consideration should be given to the use of so-called "exchange" transfusions in the severe cases.
   c. Breast feeding is not necessarily contraindicated.

Please note that some of the statements in this outline do not apply to all cases; this is intended as a practical guide, and will be found to cover satisfactorily the great majority of instances.—GORTON RITCHIE, M. D.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

PAUL WEIS

Paul Weis served as a member of the State Board of Vocational Education from 1935 to 1945, and since 1942 has been assistant state registrar and administrative head of the Bureau of Vital Statistics, State Board of Health. His wide practical experience in the statistical field has been recognized by his fellow state registrars in electing him a member of the National Council on Vital Records and Vital Statistics.

Wisconsin's Growing Population

A recent observation of one of our staff members was to the effect that statistics on any subject have a fascination that is a good deal more mathematical than rational, and that it is a good idea to preface any study of vital statistics, at least, with the observation that the finer concepts of life on this planet do not lend themselves readily to analysis by means of adding machines. This approach is recommended in connection with this brief review of current population trends and their significance to the medical profession.

The practicing physician does not need to scan Wisconsin vital statistics to be aware of the marriage and baby booms which have followed closely the end of World War II. Requests in his own office for premarital examinations, prenatal care, obstetric services, and postnatal care of mother and child give him full knowledge of this record increase at first hand.

Birth Certification More Important Than Ever

This heavy press of demands upon the physician is felt most keenly, no doubt, in those moments which he must spend in the accounting and recording that is required of him under various laws.

A plea for prompt reporting, for accuracy, and for legibility is voiced here for the good of all concerned—the individual whose birth or death is recorded, the physician who should spare himself the necessity of further correspondence in the recording, and the Bureau of Vital Statistics in performing its routine duties.

The staggering load carried by the physicians under present conditions is fully recognized by the vital statistics workers, and every effort is being made in the state offices to avoid making the burden still more oppressive.

Further Gains in Life Conservation

On the basis of preliminary figures for maternal and infant deaths in Wisconsin compared with national figures and those for certain other states, the medical profession of Wisconsin clearly is deserving of praise for its performance during a trying period.

Wisconsin's 1947 provisional live birth total stands at 84,076 at this writing, forming a record high in state annals. Infant deaths, those at age under 1 year, were limited as never before to form a rate of 29.4 such deaths per thousand live births. Another enviable record was set last year in limiting maternal deaths to 1.03 per thousand live births. These rates, all of them, are substantially lower than comparable national rates.

Prophets Can Be So Wrong

Marriage and birth statistics form the basis of population estimates, but a glance at the population forecasts made during the thirties clearly demonstrates the practical difficulties encountered in predicting trends in this field.

In 1934 the National Resources Committee mentioned the possibility of a declining population in the United States, predicting a maximum population of 138 millions in 1955 followed by a decline to 128 millions by 1980. This prediction was based, of course, on the decline of the national birth rate to a record low of 16.6 births per 1,000 population in 1933 and on the belief that the rate would continue low or even go lower. In 1933 Wisconsin's birth rate stood at 16.77. Since then it has increased 57 per cent, to confound the experts.

Year	United States			Wisconsin		
	Population	Births	Rate	Population	Births	Rate
1933*	125,578,763	2,081,232	16.6	3,008,871	50,450	16.77
1937	128,824,829	2,203,337	17.1	3,078,182	53,504	17.38
1941	133,202,873	2,513,427	18.9	3,137,587	56,572	18.0
1942	134,664,924	2,808,996	20.9	3,137,587	63,682	20.3
1943	136,497,049	2,934,860	21.5	2,945,355	64,250	21.8
1945	139,621,431	2,735,456	19.6	3,137,587	60,830	19.4
1946	141,228,693	3,129,177	23.3	3,162,606	74,176	23.25
1947**	142,656,000			3,162,606	84,076	26.6

*Estimated midyear population—National Office of Vital Statistics.
**January 1, 1947 estimate—National Office of Vital Statistics.
Population figures for the United States since 1940 are probably more reliable than those for Wisconsin, due to difficulties in appraising migration within the country.

Births as an Index to Medical Services

This tremendous upsurge of the birth rate, along with the military service demands upon the per-

(Continued on page 531)

As It Looks From the Wisconsin Veterans Medical Service Agency

T. J. DORAN

Mr. Doran, director of the Wisconsin Veterans Medical Service Agency, attended Marquette University, General Motors Institute of Technology, and the University of Wisconsin. Entering the welfare field in 1933, he worked in the Rock County Welfare Department, later became director of welfare in La-Fayette County, and in 1938 came to Madison to head the Madison Relief Department. He joined the staff of the State Medical Society in 1946.

The combined efforts of the State Medical Society of Wisconsin and the United States Veterans Administration have been pooled in order to provide the best medical care possible for the veterans with service-connected disabilities. The medical society has the talent to provide the care, and the Veterans Administration has the responsibility of determining who should get this care.

Looking back on an eighteen month period of cooperation between the medical society and the Veterans Administration, it looks from here as though discontent among the veterans and the doctors is on the increase. This discontent is caused by the fact that the veteran does not have a free choice of doctor and hospital when he needs treatment. The Veterans Administration regulations call for full use of their own clinics and hospitals before the family doctor and the local hospital can be called in to treat the veteran. It would appear that a re-evaluation of the Veterans Administration regulations would be in order.

The millions of veterans receiving medical care from the government can probably best enlighten the rest of the population of this country on how it feels to be a patient when the government is the third party in the doctor and patient relationship.

The veteran would like the privilege of being treated for his service-connected disabilities by his own family doctor in his own community. He is eligible for this treatment as a right, not as a need, but many of the veterans are refusing to go to the Veterans Administration medical centers and are instead paying for their own medical care but being unhappy about it. This growing discontent is not a healthy situation.

The family doctor is becoming irritated because he renders treatment to the veteran often times when the Veterans Administration medical center is closed and then many times his patient is later referred to a Veterans Administration medical center. If the family physician is given authority to treat the veteran, the amount of treatment must be estimated by him for each thirty day period. Additional authority must be received if the treatment is more than the estimate. It would appear to be more practicable for the Veterans Administration to authorize the necessary treatment and then have the home-town doctor present his bill at the end of every thirty day period.

Along with many other functions, the Veterans Administration has two distinct responsibilities:

1. To see that veterans with service-connected disabilities get necessary outpatient treatment.
2. To examine and re-examine veterans for pension purposes.

The Veterans Administration cannot accomplish both of these large tasks.

Like any insurance company, the Veterans Administration must protect itself by having someone other than the family physician do the examinations for pension purposes. As long as these pension examinations are very technical in nature, why not completely utilize the Veterans Administration medical centers for that purpose? There are about three million claimants receiving pensions and compensation. The necessary examining and re-examining of these veterans would keep the Veterans Administration doctors overworked.

It looks from here as though all outpatient treatment and short-term hospitalization could be accomplished to the personal satisfaction of the veteran and to the financial satisfaction of the Veterans Administration if the veteran could choose his own doctor and hospital and the Veterans Administration complete all their own examinations and provide long-term hospitalization, such as care of the mental diseases, tuberculosis, cancer, and convalescent type cases.

Time lost, travel expenses, and separation from his family are big factors in the hospitalization of veterans, especially short term hospitalization.

Several million contented veterans instead of disgruntled veterans are a big factor to our country. —THOMAS J. DORAN, *Director, Wisconsin Veterans Medical Service Agency.*

. . . . THE PRESIDENT'S PAGE . . . .

Aged and Infirm

IN 1910 the hearses were moving toward the cemeteries in unusual numbers. Three thousand cases of diphtheria among the children of Wisconsin were taking their toll. Typhoid fever was adding to the victims of contagious and infectious disease. The death rate of infants due to infant diarrhea spread through dirty, raw milk was shortening life expectancy in Wisconsin and throughout the rest of the world. Tuberculosis was called the white plague and terminated the life of young people at the beginning of their most productive period. And then something happened.

In his office as health officer of Providence, Rhode Island, Dr. Charles Chapin viewed all of this destruction of human life. He knew of the recent discoveries of the bacteria which cause these diseases. A student and thoughtful man, he contemplated the significance of this knowledge to the spread of disease. He thought of the physical nature of these bacteria. They had form but no means of locomotion; they had weight and were not wafted through the air as effluvias and miasmas as had been in the old concept. The idea that they were transferred from one individual to another, from the sick or carriers to well, susceptible people, formed in his mind. He said to himself, "These diseases are spread by direct contact of one individual with another and through dirty milk, polluted water, and insanitary conditions that breed flies and other insects." This idea was the birth of a new public health,—modern public health.

By the written and spoken word, health through the control of external environment was publicized throughout the nation and world. Scientific methods were devised for the application of what scientific investigation and astute rationalization had revealed and conceived. Health officers became experts in the application of these methods. The action of other individuals, legislators, municipal councilors, and governing bodies was necessary to put them into effect. The battle against disease was begun, and one by one communities acted to purify domestic water supplies. Cattle were tested for tuberculosis, and those that reacted were removed from the herd; clean milk was produced and pasteurized to remove the last vestige of the remaining disease-producing germs; and surgeons learned the same lesson, cleaned their hands, and sterilized their instruments. Infants passed into childhood, adolescence, and adult life because they were protected from the hazard of polluted water and dirty milk and because aseptic surgery had made safe procedures that are necessary to save life from many other diseases.

The span of life was lengthened. In 1900, 17 per cent of our population was 45 years or over; in 1940, 26.5 per cent was 45 years or more. The age distribution of our population has changed. In the decade from 1930 to 1940 the total population increased 7.2 per cent, while the group 65 years or more increased 35 per cent. There are now more than 9 million people who are 65 years old or over, and, by conservative estimate, the census bureau estimates that by 1980 this number will have reached 21 million. A new problem has been created, the care of the chronically ill and infirm.

Physicians and county judges have been acutely aware of this problem. Dr. P. R. Minahan, during his presidency of the State Medical Society 1945–46, appointed a committee to work with a similar committee appointed by the Association of County Judges to study means by which aid and medical care can be secured for this group who, though fruitful contributors to our civilization during earlier years, need aid and ameliorative medical care for their infirmity. Dr. C. A. Dawson, who succeeded to the presidency of the State Medical Society following Doctor Minahan, continued the committee appointed by the lat-

ter and wrote in his President's Page a rousing call to the aid of these old people in his editorial, "The Little Old Lady is Waiting."

The legislature in 1945 granted aid up to $80 a month for assistance to the totally and permanently disabled needing constant and continuous care. Not all of these are old people. The administration of this law was allocated to the State Department of Public Welfare, and it was soon learned that the distinction between those who need the assistance and those who are entitled to it under the provisions of the act is extremely difficult to determine if expenditure is kept within the limit of the amount of money appropriated for it.

In this situation, the Board, in order to get an idea of the magnitude of the problem, asked for a study of the number of people on the public assistance roles who were receiving or were in need of better living conditions and medical care. Part of the report of this study was given to the Board in 1946.

Wisconsin's population 65 years of age and over increased from 103,000 in 1900 to an estimated 260,000 in 1946. A conservative estimate is that this number will rise to 396,000 by 1975. Persons 65 and over constituted only 5 per cent of Wisconsin's population in 1900, but this percentage had increased to 8.2 per cent by 1946 and will be at least 12 per cent by 1975. Coincident with the rapid increase in the population 65 years and over is the increase in the occurrence of chronic invalidism. On the basis of the National Health Survey it is estimated that there are 36,000 chronic invalids in Wisconsin, excluding most of those in mental and tuberculosis institutions. Of these, 14,500, or 40 per cent, are 65 years of age or older.

The number of chronic invalids and infirm aged requiring care in institutions or nursing homes is not known. The survey made in October 1946 shows that 1 out of 4 public assistance recipients (or about 16,000 persons) was so disabled or infirm that he was unable to live alone and properly care for himself. Seventy per cent of these were living with relatives and probably will continue to do so, but 1,500 were living alone, usually under very unsatisfactory circumstances. Altogether there were 2,500 public aid recipients in need of some type of congregate care or facility, including 350 in hospitals for the acutely ill who could presumably be moved to nursing homes or infirmaries. It is believed that there are at least 5,000 persons in the state who are urgently in need of suitable institutional or nursing home facilities and probably as many as 10,000 who need better care facilities than are presently provided.

Three principal types of facilities exist for the care of infirm aged and chronic invalids: commercial nursing and boarding homes, private nonprofit institutions, and public institutions. Need for additional congregate facilities is general throughout the state but is a particularly acute problem in the northern section of the state and rural areas generally.

A study was made by the Division of 250 commercial nursing and boarding homes which take in public aid recipients, containing 2,500 residents. This study indicated that one-fourth of these homes were unsuitable in terms of meeting minimum standards of care. Overcrowding and lack of proper fire protection and sanitation were the principle shortcomings. Registered nurses were employed in only 15 per cent of the nursing homes. Thirty-five per cent of the patients in these homes were bedridden.

There are 50 private charitable homes in Wisconsin, containing 2,600 residents. Nineteen of these homes are located in Milwaukee and most of the others are in urban areas. Two-thirds of the residents are women, and many of the homes admit women only. The private charitable homes usually will not accept patients requiring a great deal of care. Only 11 per cent of the residents were bedridden, most of whom became so after admittance. These homes are the most suitable type of facility in the state and there are very few vacancies. However, they are not generally accessible to people needing such facilities because of strict admission practices. These homes need more infirmary type facilities to care for chronically ill patients.

There are 41 county and city homes operating in Wisconsin with a capacity of 3,000 beds and a population of 2,500. Half of these institutions are fifty years old or more. Only 12 are of fireproof construction. Twenty-three are unsuitable in terms of modern standards of safety and sanitation. They need more and better trained personnel, more infirmary type facilities, and improved medical programs. Seventeen counties are planning better facilities. Thirteen counties have ceased to operate county homes, five of which leased their property to private operators so as to take advantage of revenue available from old age assistance recipients. Two other counties have acquired property for lease to private operators.

The committee of physicians and county judges has worked diligently and earnestly in the preparation of suggestions for a remedy to meet this problem. They were instrumental in the drafting of a comprehensive bill permitting counties to construct infirmaries for the care of the chronically ill and infirm. It called for some unusual methods of financing. Under the present laws all who receive public assistance lose their assistance—50 per cent federal, 30 per cent state, and 20 per cent county—when they are admitted to a state or county institution for the aged and infirm. Inasmuch as this is a condition stipulated by the federal law, the bill provides that the state and counties share equally in the cost of care in the infirmaries until such time as the federal law withdrawing their share of assistance, is repealed. The committee through the state's representatives in the national Congress has requested this repeal.

The bill also provides that patients of all classes—those who can pay the full cost, those who can pay a part of the cost, and those who are unable to pay—can be admitted to these infirmaries. The bill permits a weekly charge sufficient to cover maintenance, repair, and depreciation of building and equipment as well as the cost of operation and patient care. The purpose is to encourage a high quality of service to the patients and the sharing of cost by all counties whose residents use the infirmary.

The interest of many legislators was solicited. All of them expressed awareness of the problem, concern about it, and interest in it. Because of the force of various circumstances, the proposed law could not be presented until late in the 1947 legislative session. There was insufficient time for full consideration of it, and no action was possible.

The Medical Society committee has been continued this year and the committee from the Association of County Judges also is continuing its participation with the Medical Society committee in support of this legislation. Recently a meeting was held in Madison preparatory to again seeking its consideration at the next legislative session. The executive secretary of the Association of County Boards, Mr. A. J. Thelan, was invited to the meeting. He came and was most helpful in the discussion of the provisions of the bill. Many difficulties must be hurdled, not the least of which is financing.

It is hoped that every physician will acquaint himself with the provisions of this much needed legislation and give it active support. It is true that it is only permissive legislation, and for this reason and the difficulties in financing, it may be slow in getting at the problem. However, without it nothing will be done; with it and the interest of citizens in the well-to-do counties, a beginning to the solution can be made before it becomes a shocking circumstance to human decency.

The wheels of progress are turning, though ever so slowly. New successes bring new problems. In one era prevention of disease brings success at which some marvel, only to usher in another which creates a state of quandary. But we dare not let them stop; prevention must progress while we search for a solution of the problem which has thus been created. The purpose of all humane effort is the promotion of the welfare of mankind and the preservation of the dignity of each individual without which all is lost.

W D Stovall

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« « « EDITORIAL » » »

IN PLACE of a guest editorial, which customarily appears on the opposite page, we carry an item on the "Spring Clinics," which have become an established part of the postgraduate program of the State Medical Society of Wisconsin.

While changing times have forced the average physician to divide his attention between scientific medicine and the delivery of medical care under new programs of medical and hospitalization insurance, the importance of advances in scientific medicine necessitates an expansion of postgraduate teaching. Each year brings new discoveries from the laboratories of medical science, and while the alert physician acquires much of his new information through scientific journals, there is nothing so effective as the classroom technic provided through actual teaching courses.

During the past decade the State Medical Society of Wisconsin has developed a scientific program which has few, if any, counterparts in the United States. Besides providing an intensified three day scientific program as a part of the Annual Meeting, the Council on Scientific Work has provided scientific programs in industrial health, cancer, and the usual coverage of obstetrics, internal medicine, surgery, and pediatrics in the annual "Spring Clinics." Through the coordination of these various activities, the Council on Scientific Work is able to offer postgraduate education to physicians in all parts of the state.

A review of the "Spring Clinic" program prepared by Dr. J. M. Freeman, Wausau, will indicate the practical aspects of the presentations. All members of the faculty are skilled teachers, and the fields they are to cover are of special concern to the general practitioner. Common problems of obstetrics will be covered by Doctor Harris; the emotional problems of children and adults will be presented by Doctor Jensen; Doctor Schaefer will present the subject of pediatric surgery; and the field of endocrinology will be discussed by Doctor Thompson.

To bring such teachers to the doorstep of members of the State Medical Society of Wisconsin is a gratifying experience for the Council on Scientific Work. The success of these clinics depends entirely upon the response of the profession. Your participation in the programs will do much to encourage the development of similar postgraduate experiences for the benefit of Wisconsin physicians.

"Spring Clinics"

- LA CROSSE ---------- JUNE 1
- WAUSAU ---------- JUNE 2
- MANITOWOC ---------- JUNE 3

J. M. FREEMAN, M. D.
Program Chairman

TEACHING FACULTY

JOHN W. HARRIS, M. D.
Professor of Obstetrics and Gynecology
University of Wisconsin Medical School
"Bleeding in Late Pregnancy . . Causes and Treatment"
"Recent Trends in Clinical Obstetrics"

REYNOLD A. JENSEN, M. D.
Associate Professor of Pediatrics
University of Minnesota Medical School
"The Physician and Preventive Psychiatry"
"Physical Complaints Without Organic Basis"

ARTHUR A. SCHAEFER, M. D.
Assistant Clinical Professor of Surgery
Marquette University School of Medicine
"Problems in Pediatric Surgery"
Clinical Case Study in Pediatrics

WILLARD O. THOMPSON, M. D.
Clinical Professor of Medicine
University of Illinois College of Medicine, Chicago
"Androgen and Estrogen Therapy"
"Present Status of Treatment of Toxic Goiter"

PATHOLOGICAL CLINICAL CONFERENCE

In the late afternoon of each clinic the local county medical society will present a pathological clinical conference, with all four members of the faculty as participants. This will be a new feature of the "Spring Clinics" and promises to be of special interest to those in attendance.

Register!

The registration fee of $4.00 will cover the noon luncheon and defray, in part, the expenses of speaker honorariums and publicity. The balance will be withdrawn from the treasury of the State Medical Society from funds provided the Council on Scientific Work for scientific teaching programs.

(USE REGISTRATION SLIP ON PAGE 482)

WE ANTICIPATE A *Shortage!*

The Wisconsin Pharmaceutical Association is meeting at the Hotel Pfister the same days as our Annual Meeting. This, plus heavy commercial travel, will mean a scarcity of rooms. RESERVE YOURS NOW ON THE FORM BELOW. Remember: If you are a delegate, councilor or officer, start your reservation Saturday, October 2, as the first session of the House of Delegates is Sunday afternoon. Scientific sessions are on Monday, October 4, through Wednesday, October 6. Reserve for the entire time, as the 1948 program is exceptionally strong, right up to 5:30 p. m., Wednesday.

Headquarters, meetings of the House of Delegates, Round-Table Luncheons, and the Annual Banquet will be held at the Hotel Schroeder.

Hotel Medford:

Single without bath	$1.75
Single with bath	2.50 to $3.25
*Double without bath (*toilet and lav.)	3.25 to 3.50
Double with bath	3.50 to 4.50
Twin without bath	3.50 to ---
Twin with bath	5.00 to 6.00

Hotel Pfister:

Single without bath	$2.75 to $4.40
Single with bath	3.30 to 7.70
Double without bath	4.95 to 6.60
Double with bath	5.50 to 9.90
Twin without bath	4.95 to 6.60
Twin with bath	5.50 to 9.90

Plankinton House:

Single without bath	$ --- to $ ---
Single with bath	3.30 to 5.50
Double without bath	--- to ---
Double with bath	4.50 to 6.60
Twin without bath	--- to ---
Twin with bath	5.50 to 8.80

Randolph Hotel:

Single without bath	$2.00 to $ ---
Single with bath	2.50 to 3.50
Double without bath	3.25 to ---
Double with bath	3.75 to 5.50
Twin without bath	None
Twin with bath	5.00 to 5.50

Hotel Schroeder:

Single without bath	$2.75 to $ ---
Single with bath	3.50 to 7.70
Double without bath	--- to ---
Double with bath	6.00 to 8.80
Twin without bath	--- to ---
Twin with bath	7.00 to 12.00

Hotel Wisconsin:

Single without bath	$1.75 to $2.00
Single with bath	3.00 to 6.00
Double without bath	2.75 to 3.00
Double with bath	4.25 to 7.50
Twin without bath	None
Twin with bath	6.00 to 9.00

HOTEL RESERVATION BLANK

Mail This Coupon to Hotel Selected

Manager, _____ Hotel, Milwaukee, Wisconsin.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the State Medical Society of Wisconsin, October 4, 5, and 6, 1948, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite ☐ Other _____

Arriving October _____ at _____A. M. _____P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

HAROLD C. UREY, Ph. D.

An Announcement

C. H. CROWNHART
Secretary

ROY T
A

STATE MEDICAL SOCIETY OF WISCONSIN

W. D. STOVALL, M. D.
President

To All Members of
The State Medical Society

Dear Doctors:

I am very pleased to inform you that as guest speaker for the Annual Dinner, to be held at the Hotel Schroeder, Tuesday evening, October 5, Dr. Harold C. Urey, distinguished service professor of chemistry, University of Chicago, will speak to us on the subject: "Social Implications of Atomic Energy."

Doctor Urey's attainments as a scientist have been recognized by a Nobel prize award, and we are honored to have him as our banquet speaker.

The entire three days of scientific meetings give promise of providing us with lectures and discussions of great value. The Council on Scientific Work is to be congratulated on the program they have provided for us.

Your presence at the Annual Meeting will do much to make it a success.

Cordially yours,

W D Stovall

President.

SCIENTIFIC PROGRAMS

ANNUAL MEETING

E. R. SCHMIDT, M. D.
General Program Chairman

OCTOBER 4, 5, 6, 1948
MILWAUKEE

On this and the following two pages a preliminary outline of the 1948 Annual Meeting is given so that physicians can make proper plans for attendance. An exceptionally fine scientific program has been arranged for each of the three days, beginning with a series of clinical teaching conferences the opening day, Monday, October 4, and concluding with section programs on Wednesday afternoon, October 6. This latter change in schedule is highly important to note, as for the past several years the section meetings have been held on Tuesday.

Physicians are urged to make plans to be in attendance all three days of the meeting. Distinguished guests are appearing on the programs each of the three days, and the sustained high quality of scientific papers throughout the meeting warrants attendance of the full three days: October 4–5–6.

MONDAY OCTOBER 4

9:00–11:30 a. m.: Three Oustanding Clinical Conferences:

Milwaukee Children's Hospital: Participants: Drs. J. L. Garvey, F. J. Mellencamp, A. A. Schaefer, H. P. Maxwell, David Cleveland.

Milwaukee County Hospital: Participants: Drs. M. C. F. Lindert, J. G. Garland, Joseph Shaiken, C. F. Conroy, J. W. Rastetter, J. J. Gramling, J. M. King, F. D. Murphy.

Veterans Hospital, Wood: Participants: Drs. M. J. Lustok, M. W. Garry, J. J. Furlong, Ray Piaskoski, R. A. Frisch, R. T. Cunningham, J. M. Sullivan, H. L. Correll, C. M. Schroeder, W. H. Frackelton.

12:15– 2:15 p. m.: Round-Table Luncheons: Leaders: Drs. H. W. Brosin, N. H. Topping, E. A. Graham, J. M. King, Forrester Raine, T. L. Squier, F. R. Janney, W. S. Middleton, C. M. Kurtz, S. F. Morgan.

2:30– 5:00 p. m.: General Scientific Program: Guest speakers: Drs. N. H. Topping, Bethesda, Maryland; E. A. Graham, St. Louis; H. W. Brosin, Chicago

TUESDAY OCTOBER 5

9:00–11:30 a. m.: General Scientific Program: Guest speakers: Drs. J. B. Youmans, Chicago; H. P. Greeley, Boston; Arnold Gesell, New Haven, Connecticut.

12:15– 2:15 p. m.: Round-Table Luncheons: Leaders: Drs. Arnold Gesell, E. S. Gordon, J. B. Youmans, H. P. Greeley, J. L. Baer, O. O. Meyer, E. L. Belknap, H. R. Foerster, G. E. Shambaugh, Jr., M. E. DeBakey, Frank Whitacre, H. M. Murdock, R. H. Freyberg.

2:30– 5:00 p. m.: General Scientific Program: Guest speakers: Drs. M. E. DeBakey, New Orleans; R. H. Freyberg, New York City; H. M. Murdock, Towson, Maryland; J. L. Baer, Chicago.

7:00 p. m.: Annual Dinner: Address by Dr. Harold C. Urey, Chicago, distinguished scientist in the field of atomic energy and Nobel prize winner.

WEDNESDAY OCTOBER 6

9:00–11:30 a. m.: General Scientific Program: Guest speakers: Drs. O. H. Wangensteen, Minneapolis; B. R. Kirklin, Rochester, Minnesota; Charles Watkins, Rochester, Minnesota.

12:15– 2:15 p. m.: Round-Table Luncheons: Leaders: Drs. A. C. Gorder, Charles Watkins, F. A. Gibbs, W. A. McGee, O. H. Wangensteen, W. D. Stovall, F. D. Murphy, R. L. J. Kennedy, F. W. Madison, I. R. Sisk, W. H. Frackelton.

2:30– 5:30 p. m.: Section Programs (see following two pages).

All Sections On WEDNESDAY-OCT. 6

GENERAL PRACTICE — Woodruff Smith, M. D., Chairman

Speakers: "The Care of Hip Fractures in a Rural Community": R. L. MacCornack, M. D., and R. M. Rogers, M. D., Whitehall

"Some Aspects of Cardiovascular Disease in the Elderly Patient": H. P. Greeley, M. D., Boston

"The Handling of the Menopause Group": H. M. Murdock, M. D., Towson, Maryland

INTERNAL MEDICINE — Elwood Mason, M. D., Chairman

Speakers: "Some Aspects of Nutritional Anemias": J. B. Youmans, M. D., Chicago

"Treatment of Tuberculosis with Streptomycin": G. C. Owen, M. D., Milwaukee

"Diagnosis of Lymph Node Enlargement": J. S. Hirschboeck, M. D., Milwaukee

"Arthritis": R. H. Freyberg, M. D., New York City

OBSTETRICS & GYNECOLOGY

C. S. Harper, M. D., Chairman

Speakers: "The Physiology of the Endocrines as Related to Obstetrics and Gynecology": R. K. Meyer, Ph. D., Madison

"The Use and Abuse of Endocrine Products in Obstetrics and Gynecology": P. F. Schneider, M. D., Evanston, Illinois

"Eclamptic Toxemia": Frank Whitacre, M. D., Memphis, Tennessee

"Distribution of Whole Blood, Blood Plasma, and Blood Products Through Community Blood Banks"; W. D. Stovall, M. D., Madison

OPHTHALMOLOGY & OTOLARYNGOLOGY

J. K. Trumbo, M. D., Chairman

Speakers: "Clinical Allergy for the Nose and Throat Specialists": T. L. Squier, M. D., Milwaukee

"The Fenestration Operation: Selection of Cases and Training of the Surgeon": G. E. Shambaugh, Jr., M. D., Chicago

"The Accommodative and Convergence Factors in Refraction": A. D. Prangen, M. D., Minneapolis

"The Incision and Closure of the Wound in Cataract Operations": F. A. Davis, Madison

[Continued on Next Page]

PEDIATRICS — M. G. Peterman, M. D., Chairman

Speakers: "Exophthalmic Goiter in Children": R. L. J. Kennedy, M. D., Rochester, Minnesota

"Practical Aspects of Electroencephalography": F. A. Gibbs, M. D., Chicago

"Differential Developmental Diagnosis": Arnold Gesell, M. D., New Haven, Connecticut

"Pediatric Allergy": W. A. McGee, M. D., Richmond, Virginia

"What the Practitioner May Expect from the Laboratory": Gorton Ritchie, M. D., Milwaukee

"Some Problems in Roentgenology in Children": J. L. Marks, M. D., Milwaukee

RADIOLOGY — S. R. Beatty, M. D., Chairman

Speaker: B. R. Kirklin, M. D., Rochester, Minnesota

Case reports presented by: E. A. Pohle, M. D., and J. H. Juhl, M. D., Madison; H. W. Hefke, M. D., Milwaukee; S. A. Morton, M. D., Milwaukee; H. H. Wright, M. D., Milwaukee; and L. W. Paul, M. D., Madison

SURGERY — F. D. Weeks, M. D., Chairman

Speakers: "Carcinoma of the Ampulla of Vater": K. E. Lemmer, M. D., Madison

"Present Status of Vagal Resection": P. A. Midelfart, M. D., Eau Claire

"Carcinoma of the Breast": C. W. Eberbach, M. D., Milwaukee

"The Surgical Treatment of Colon Malignancy": O. H. Wangensteen, M. D., Minneapolis

"The Surgical Treatment of Peripheral Vascular Disease": M. E. DeBakey, M. D., New Orleans

EXHIBITS:

A large selection of scientific and technical exhibits will be presented, covering the entire floor space of the Milwaukee Auditorium Main Arena. F. W. Madison, M. D., Milwaukee, is in charge of the selection of scientific exhibits, and his final listing of all scientific exhibits will be carried in the August issue of *The Journal.*

SMOKER:

On Monday, October 4, the State Medical Society will present its annual evening of informal entertainment for the benefit of exhibitors and physicians in attendance at the Annual Meeting. It will be an evening of relaxation and good-fellowship.

Minutes of the Council Meeting, Madison, December 13, 1947

1. Call to Order

The Council was called to order by Chairman Gavin at 2:10 p.m. Saturday, December 13, 1947, at the Hotel Loraine, Madison.

2. Roll Call

Councilors present were Doctors Wilkinson, Hemmingsen, Vingom, Dessloch, Heidner, Gavin, Fox, Bell, Chistofferson, Arveson, Ekblad, Witte, Fitzgerald, Truitt, and Leahy.

Also present were President Stovall; President-Elect Doege; Treasurer Sisk; Doctor Supernaw, chairman, Committee of Wisconsin Veterans Medical Service Agency; Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, director, Wisconsin Veterans Medical Service Agency; Mr. R. F. Weber, director, Wisconsin Physicians Service; Executive Assistant Thayer; and Miss Kracht.

3. Interim Report of the Secretary

Before presenting the interim report, the secretary directed the attention of the Council to several communications. One was from Dr. W. C. Hanson, Racine, a member of the recently formed "Fifty Year Club." It was an expression of thanks to the Council for the honor bestowed upon him by being elected a member of the "Fifty Year Club."

The second communication was from the Auxiliary of the State Medical Society, expressing appreciation to the Council for its assistance during the course of the annual meeting.

A third communication was from Doctor Beebe of Superior, thanking the Council for voting him a life member of the State Medical Society. In presenting the interim report, Mr. Crownhart covered briefly the activities of the secretary's office since the time of the annual meeting, reviewing committee activities and various conferences in which members of the office staff had participated. He directed special attention to the North Central Medical Conference held in St. Paul and the Conference of State Medical Association Secretaries and Editors held in Chicago on November 7 and 8. He reviewed in considerable detail the programs of these two meetings and reported on the developments of the Associated Medical Care Plans Program as described by Doctor Schriver, who participated in the meeting of secretaries and editors at the American Medical Association conference. Having concluded a description of the various conferences attended, Mr. Crownhart directed the attention of the Council to the social security activities of other groups, particularly the State Chamber of Commerce and its committee on social security, of which he is a member. He reviewed some of the actions taken by the committee on social security of the State Chamber of Commerce. He reported that the committee on social security had recently gone on record as opposing compulsory health insurance of the character of the Wagner–Murray–Dingell Bill, but that the committee had expressed considerable interest in the development of cash disability insurance. The secretary felt that this matter was of growing importance and that the Council and general membership of the State Medical Society should become well acquainted with developments in this field. He further reported that there had been considerable activity in cooperative circles as to the application of the recently enacted Enabling Act and indicated that all of this activity is not in rural circles alone but also in urban centers. He described in detail some of the activities in Kenosha County, where a cooperative health group has been formed among the laboring leaders who are now engaged in making a detailed survey of the medical care and hospital care facilities in Kenosha County with the view of organizing a health cooperative and possibly establishing a cooperative hospital. Recently, he reported, a Miss Margaret Stein of Washington, D.C., had consulted with him as to the attitude of the medical profession toward the development of cooperative health programs. Miss Stein had formerly been connected with the Farm Security Administration, was later on the Truman committee staff, and is now closely associated with Michael Davis. From the nature of his conference with Miss Stein it seemed apparent to the secretary that the Committee on Research and Medical Economics is beginning to undertake a very active program in the field of encouraging the development of cooperatives, both in rural and in urban areas. In describing the development of health insurance programs among rural groups, the secretary reported that the Wisconsin Farm Bureau had recently met in session and had commended the State Medical Society for its work in developing the Wisconsin Plan for hospital, surgical, and obstetric care and urged their members to continue and increase their efforts to gain acceptance and participation by all doctors in the state. Secretary Crownhart reported that at the time of the Council meeting the Farm Bureau had gone on record as definitely opposing any form of compulsory government-sponsored insurance program.

4. Introduction of New Councilors

Dr. S. E. Gavin, chairman of the Council, introduced Doctor Hemmingsen of Racine as the new councilor for the Second Councilor District, Doctor Fox of La Crosse as councilor for the Seventh

Councilor District, and Doctor Bell of Peshtigo as newly elected councilor for the Eighth Councilor District.

5. Interim Report of the Veterans Medical Service Agency

Dr. J. S. Supernaw, chairman of the operating committee of Veterans Medical Service Agency, spoke briefly concerning the development of the program and introduced Mr. T. J. Doran, director, who described to the Council in considerable detail the development of the program since last reported to the Council. He reported that the agency had started business on November 1, 1946, and that at the end of October 1947, $522,000 in authorizations had been handled by the agency. Of this amount, $382,000 worth of authorizations had been received back from the doctors. Of this amount of $382,000 in authorizations, $344,000 had been paid by the Veterans Administration in cash and $313,000 had been paid directly to the doctors for services rendered. Forty thousand dollars of authorizations had been cancelled either because the veteran did not get back to the doctor after authority was granted or because the doctor felt that there was no further treatment necessary. His report indicated that an additional $53,000 worth of authorizations had been cancelled because of only partial use where the physician would request a certain number of office calls and then use only a small proportion of the office calls requested. This represented about 20 per cent of the business that had been actually authorized and had been cancelled by the physician or the patient not taking advantage of the service. Mr. Doran's report further stated that $30,000 had been allocated to the administrative fund, which represented approximately 10 per cent of the fund collected from the Veterans Administration for services rendered to them. The money paid into the administrative fund had been supplemented by an initial loan from the State Medical Society, which in total represented an administrative fund of $46,000. Mr. Doran's report indicated that at the end of the first year the agency had $9,500 left in the administrative fund. He gave a detailed explanation of the various expenditures in administration, giving a sum of $20,000 spent for salary; $900 for travel expenses; $7,500 for office supplies and expenditures; and $8,000 for general expenses, including office rent, light, telephone and telegraph, meeting expense, legal and auditing services, etc. His report indicated that the agency had rendered a service to approximately 13,500 different veterans, these veterans being cared for by 1,265 different physicians and 25 clinics. Mr. Doran reported that there was a total of 2,465 Wisconsin physicians participating in the program. He described the new type of contract which will govern the agency during the ensuing year. The most important feature of this new contract, in the opinion of Mr. Doran, is the change which will require a statement on the part of the physician indicating that the fee or fees charged are not in excess of the fees charged non-veterans for the same type of service rendered. This new rule was insisted upon by the Veterans Administration as the result of experience in some states of alleged abuse on the part of physicians in charging the Veterans Administration a higher fee than charged to other persons rendered the same service. Mr. Doran was pleased to report to the Council that no such abuse has occurred in Wisconsin, and he pointed out numerous instances in his experience during the past year where physicians have not charged as much as they were allowed to charge on the schedule agreed upon by the Veterans Administration. Mr. Doran described to the Council a recent conference held in Chicago for administrators of various state plans and representatives of the Veterans Administration. General Hawley and Colonel Harding were in attendance at this meeting. It was the feeling of Mr. Doran that General Hawley has a very sound philosophy in the administration of the Veterans Administration program and that he desires to work in close harmony with state medical societies to secure the best possible medical care for the veterans being taken care of under the program of the Veterans Administration. Mr. Doran felt, however, that this philosophy had not always permeated into the local offices, and as a result there was considerable difficulty with the administration of the programs along the line suggested by General Hawley. Mr. Doran reported that many of the administrators of local Veterans Administration agencies were strongly advocating the development of Veterans Administration clinics and thus tending to eliminate the free choice of medical care. Many of those in attendance at the Chicago conference expressed fear that the creation of new facilities and the expansion of existing facilities might result in the abandonment of the home town program. To relieve this expression of fear General Hawley pointed out to those in attendance at the conference that the establishment of clinics had not kept pace with the case load and that under those circumstances there would be little basic change in the philosophy of having the veterans cared for by their family physician. General Hawley's report indicated that after the first world war that there were approximately four million veterans to be taken care of under the Veterans Administration program and that there were a total of 51 clinics operating to take care of veterans under the Veterans Administration programs. At the close of World War II there were approximately 18 million veterans to be cared for, and there were only 70 clinics being operated under the direction of the Veterans Administration. Interpreting these statistics in the number of veterans per clinic, the original ration following World War I was 1 clinic for each 127,000 veterans. At the present time the ratio is 339,000 for each clinic under the direction of the Veterans Administration. General Hawley had expressed the personal desire to have all veterans cared for

(Continued on page 499)

The
MEDICAL FORUM

The Wisconsin Medical Journal — May, 1948

Wisconsin Doctors at National Health Meet

Ewing to Recommend National Health Insurance Program

Madison, May 4.—Six Wisconsin physicians were among the delegates to a national health assembly called by Federal Security Administrator Oscar Ewing in Washington, May 1–4, to help develop a 10-year health program for the nation.

Those who attended from the State Medical Society were Dr. Llewellyn R. Cole, coordinator of graduate medical education at the University of Wisconsin; Dr. Carl N. Neupert, state health officer; Dr. Gunnar Gundersen, La Crosse, president of the State Board of Health; Dr. J. W. Truitt, Milwaukee, and Dr. Lyman A. Copps, Marshfield. Mr. C. H. Crownhart, secretary of the state medical society, and Dr. C. A. Elvehjem, dean of the university graduate school, also attended.

The assembly was called after President Truman had requested Mr. Ewing to develop feasible national health goals for the next 10 years.

Mr. Ewing declared that he did not intend to be bound by the conclusions reached at the conference, but would draw upon them for background and information. He said that he "was very much in favor of a national health insurance program" and that he would recommend such a plan to President Truman as part of his report.

ON THE INSIDE

Subject	Page
Anesthetists	4
CIO Health Demands	5
Co-op Federation	3
Duluth Co-op	8
Emergency Medical Service	3
Health Bills in Congress	2
Military Medical Training	6
Public Health Officers	8
Secretaries' Conferences	7
Socialized Editors?	8
Study State Health Board	6
Swindle Doctors	6
Vets Train for Medicine	2
Wisconsin Physicians Service	5
Wisconsin Plan	4

Propose Emergency Medical Service Program for Wisconsin as Civil Defense Measure

Dr. Sargent Urges Action to Meet Possible Disaster

Milwaukee, April 30.—A civil defense program for Wisconsin should have top priority in the State Medical society's plans to aid the work of the AMA Council on National Emergency Medical Service, Dr. James C. Sargent, Milwaukee, chairman of the Council, declared today.

Following the lines suggested at a national meeting of the Council in Chicago on April 5–6, Dr. Sargent recommended that the society's committee on military medical service be immediately activated to:

1. Stimulate Wisconsin government officials to develop a state civil defense program along lines recently suggested by Secretary of Defense Forrestal.

2. Undertake a survey of the probable medical, health and sanitary problems that would arise in this state in event of another war.

3. Undertake a survey of the facilities and personnel available in the state and separate sections of the state to meet the serious problem of civilian casualties that would be likely to occur in another war.

Dr. Sargent strongly urged that everything possible be done to encourage the President, Secretary of Defense and chairman of the National Security Resources board to form an agency within the board charged with the job of over-seeing the allotment of the limited medical manpower of the nation to civilian and military needs in time of national emergency.

He pointed out that too many medical men are occupying administrative positions that could be handled by non-medical personnel and that the military establishment has a tendency to "overman the armed services with unnecessary medical personnel."

May Have 30,000 Attend Annual AMA Convention

Chicago—A possible total registration of 30,000 persons at the annual American Medical Association convention to be held in Chicago, June 21–25, is anticipated by Thomas R. Gardiner, business manager of the association.

More than 6,000 hotel rooms will be required to handle the out-of-town physicians expected to attend the session. These doctors, plus the large number living in the Chicago area, will bring the total number of medical men registering at the session to 12,000. Wives, guests, exhibitors and others will raise the total to about 30,000.

Technical exhibits, presenting the latest in modern medical and surgical supplies, will occupy at least 50,000 square feet of space on Navy Pier.

VETS NEED CLAIM TO GET TREATMENT

Claim Must Be Established Before Care Is Authorized

Madison, May 6.—Many physicians are requesting authority to treat veterans and their requests are being denied because the veteran has not filed a claim, Mr. Thomas J. Doran, director of the Wisconsin Veterans Medical Service Agency, reports.

A claim must be established before the VA can authorize outpatient care for service-connected disabilities. When a request for treatment is received in the Veterans Administration office and no claim has been filed, the VA sends the necessary papers to the veteran to file a claim.

Encouragement should be given to the veteran to complete the papers and forward them to the VA so that when further treatment is requested, the claim will have been established.

Many Health Measures in Congress Are Pigeonholed

Dr. Joseph S. Lawrence of AMA Washington Office Tells Status of Pending Legislation

Washington, D. C., April 30.—The leaders of Congress have announced their intention of attempting to finish the duties of the 80th Congress by June 19th. Shortly after the adjournment, a complete history of each bill affecting health and medicine will be printed. In the meantime, it will be interesting to make a brief review of what are considered the most important bills.

S. 545, known popularly as the Taft Health Bill, and S. 1320, known as the Wagner–Murray–Dingell (WMD) Bill, were extensively discussed before the senate committee on labor and public welfare without a decision being reached. In fact, the hearings were never terminated. Companion bills in the house were pigeonholed without hearings.

S. 140, the bill which would authorize the creation of a new executive department with cabinet rank, the Department of Health, Education, and Security was approved in amended form by the senate committee on expenditures in executive departments, but so far attempts to bring it before the senate for discussion have failed. Its companion in the house was pigeonholed.

No Action on S. 1290

S. 678, a bill introduced by Senator Lodge, Massachusetts, provides that federal subsidy should be made available to welfare officers for assistance in providing drugs and services which are considered too expensive by the ordinary welfare department. This bill carries no means test, a matter which was discussed very freely with Sen. Lodge when the bill was given hearing. The committee has indicated no action since the hearing and there is no companion bill in the house.

S. 1290, the National School Health Services Act of 1947, was introduced by Sen. Saltonstall. The bill as introduced provided for federal assistance in securing physical and medical examination of school children, but when Federal Security Administrator Ewing testified at the hearing he offered amendments under which the services were to be extended to all children and youth of school age and provided that the bill should subsidize instruction in physical education. Saltonstall was not prepared to accept the amendments. An AMA representative testified that in principle the bill could be approved but offered two recommendations: (1) that the school physician making the examinations should be obliged to consult with the family and with the family physician and (2) that if a difference of opinion arose between a state and the federal security administrator with regard to the program under which the examinations would be conducted, provision should be made that appeal to the court for its adjudication shall be possible. The campanion bill in the house (H. R. 1980–Howell) was given a hearing, but no further action has come from either committee.

Dr. J. S. Lawrence.

S. 1714, introduced by Sen. Pepper, provides that federal aid be given states for maternal and child health protection. This bill would continue the wartime EMIC program. The committee on labor and public welfare has not given the bill a special hearing, although its principles have been discussed in conjunction with S. 1320. It appears to be pigeonholed indefinitely.

S. 2189 is a bill to assist states in the development and maintenance of public health units by means of subsidy. Proponents argued that many communities in the U. S. do not have public health facilities readily available or are not administered properly for lack of funds. An AMA representative approved the principles involved but called attention to the fact that the AMA has advocated local health units since 1883 and that the House of Delegates has several times adopted resolutions looking toward the accomplishment of this objective. The committees still have their respective bills under consideration.

S. 1734, a bill introduced by Sen. Murray and others, provides a program of compensating workmen for time lost due to illnesses not related to their job. Similar laws are now operating in Rhode Island and California. The bill is pigeonholed with the committee on labor and public welfare.

Obviously we cannot possibly forecast with accuracy what will happen to any of these bills. Congress may decide that there is a definite need for the enactment of some of them, but at present it is not inclined to increase expenditures except for matters of defense. It is, therefore, likely to lay aside all legislation involving budgetary increases until the demands of the armed services are satisfied.

One of Every 25 Veterans Training for Medicine

Washington, D. C., May 1.—One in every 25 World War II veterans training under the G. I. Bill is preparing for a career in medicine or in a related field, a Veterans Administration survey has revealed.

On December 1, 1947, nearly 102,000 ex-servicemen and women were enrolled in educational institutions and were training on-the-job for medical positions and professions ranging from laboratory technicians to surgeons.

More than 40 percent, or 43,558 were studying medicine. Of these, 18,265 were in pre-medical training and 25,293 were enrolled in medical schools.

In other categories, 17,486 veterans were in dental training; 13,245 training in pharmacy, 5,194 for laboratory technicians and assistants, 6,835 in optometry, 4,459 in nursing, and 3,463 in chiropractic.

Council Seeks Way to Meet Emergency

125 Delegates Discuss Atomic Warfare and Disaster Control

Chicago, April 6.—A significant and highly successful meeting of the AMA's Council on National Emergency Medical Service was held in Chicago, April 5–6, with more than 125 representatives of state medical societies, national health and disaster groups and members of the armed forces.

Army, Navy and Air Force medical men presented the medical implications of special weapons warfare. Some sessions were held behind closed doors by security reasons. Others told of the part to be played by militiary and civilian groups in time of national emergency and the need of medical personnel for the armed forces.

Map Six Point Program

The Council, under the leadership of Dr. James C. Sargent, Milwaukee, chairman, and Dr. Richard L. Meiling, Columbus, Ohio, secretary, presented a 6-point program.

1. One medical examination to cover screening, induction and assignment of selectees;
2. Refrain from "calling up" medical officers for service until actual employment for medical care of patients is required.
3. Adoption by the armed forces of the VA medical program type of relationship with the civilian medical facilities and personnel within continental United States.
4. Give civilian medical officers ranks equal to career men of the armed forces.
5. Continue medical scientific education and essential civilian medical and scientific research throughout national emergency.
6. Establish a National Emergency Medical Board as an agency of the National Security Resources board.

Ask Higher Doctor Ratio

In view of the probability of atomic or other highly destructive bombing, the Council strongly asserted that "it would be completely unsafe and a serious threat to our national war effort to needlessly lower the ratio of physicians to civil population anything like that of the 1 to 1500 ratio reached during the recent war."

CO-OPS SET UP REGIONAL FEDERATION TO PROMOTE HOSPITAL–MEDICAL PLANS

Milltown Hospital Rally Tests Local Support

Madison, May 6.—Plans for a regional federation of the Cooperative Health Federation of America got the go-ahead signal from delegates to the Group Health association annual meeting in St. Paul, April 10.

Under a plan previously worked out with co-ops in the area, Group Health Association will contribute the major part of the budget and use its offices and staff facilities in the federation's work. Participants are Group Health association, Central Cooperative Wholesale, Superior, and Midland Cooperative, Minneapolis.

Adoption of the plan means that cooperatives in the region are ready to go ahead with a campaign of organization which will include promotional help, research, survey services, technical counsel and and other aids to local health co-ops.

One new co-op health group in the area already has been chartered and is organizing, and at least four others are in stages of preliminary planning. The incorporated organization is the Polk–Burnett Cooperative Health Ass'n., Milltown, Wis. Articles have been filed for a hospital cooperative at Wild Rose, Wis., and for the Superior Cooperative Health Ass'n.

Health cooperatives are also being organized at Racine and Kenosha. In Minnesota the principal organizing activity is in Duluth where the Arrowhead Health Center has been set up and is enrolling members.

At Milltown on May 4 the organizers of the Polk–Burnett Cooperative Health Ass'n. held what they termed a "co-op hospital rally." The purpose was to "fully explain this project and clear up misunderstandings."

The *Burnett County Siren* of April 29 reported that the meeting will "to a certain extent, test the support that the project will have in its home community. It is being planned as an area hospital and can be build large enough if sufficient funds are forthcoming. It can be maintained without undue burden and at attractive rates if a large block of prepayment medical care plans are subscribed."

"The Milltown meeting, besides being educational, will open the campaign for hospital memberships," the paper reported. "An opportunity will be given to take out memberships and to join the medical care and hospitalization plan. Pledges will also be accepted."

At the annual meeting in St. Paul, Rep. Richard Silvola, Virginia, Minn., called upon the cooperators to make enabling legislation for health cooperatives in Minnesota, along with Governor Youngdahl's public health district program, a principal issue of the next election. Rep. Silvola was principal author of co-op enabling legislation which failed of passage in Minnesota at the last legislature.

A MOMENT OF FORETHOUGHT

Doctors taught the world that *an ounce of prevention is worth a pound of cure.*

Insurance could well rephrase this to be *a moment of forethought is worth years of regret.*

Don't risk being without proper disability insurance. Take a few moments now to be sure your plan of protection is adequate. Your local TIME agent can offer valuable assistance.

Write us for an analysis of our special disability policy for Professional men.

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213 W. Wisconsin Ave.
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New Wisconsin Plan Policies Are Effective on May 31

Farm Bureau Ends Year With 10,000 Coverage

Madison, May 1.—A new schedule of benefits will go in effect after May 31, 1948, when new policies will be written for the Wisconsin Plan of prepaid hospital, surgical and obstetric care, the State Medical Society has announced.

Major changes in the benefit schedule are increases from $25 to $35 for tonsillectomy and adenoidectomy and from $50 to $60 for baby delivery. The new schedule of benefits is being sent to all participating physicians.

2,200 Doctors Participate

A number of insurance companies have submitted their new policies for consideration of the society's committee on insurance, and all are expected to be ready to go by May 31.

The 1948 panel of participating physicians is being distributed to insured persons through their insurance companies. More than 350 physicians' names have been added to the panel, bringing the total number of participating doctors to nearly 2,200.

The month of May marks the end of the first year of Wisconsin Plan insurance for Wisconsin Farm Bureau members, reports Mr. Hal Kautzer, director of the Farm Bureau health department. More than 3,000 member families, or nearly 10,000 persons, are insured under the plan, he said.

Request Full Statement

Premium income from Farm Bureau members for the first year was more than $100,000, Kautzer said. Now in 25 counties, the Farm Bureau groups of the Wisconsin Plan began a year ago in Green Lake county where the first health improvement association was formed and the required number of policies secured. Manitowoc county Farm Bureau members have more than 200 policies in effect and Trempealeau county has the highest percentage of members subscribing.

Typical of the response of Farm Bureau members to their Wisconsin Plan coverage is this letter from a Bagley, Wis., resident:

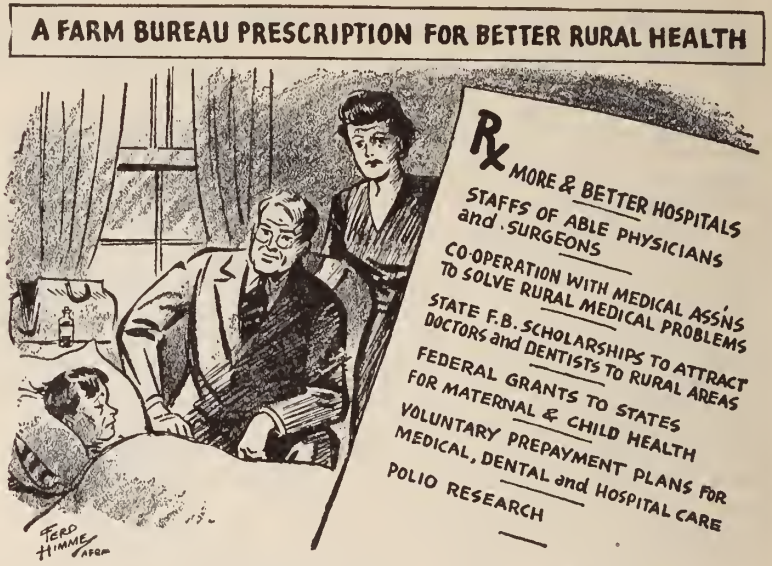
"Wish to thank you for the way you handled our insurance. My husband and I are engaged in promoting the Wisconsin Plan in our township of Westford and Dodge county. Now that we have actual proof that everything is fair and exactly the way as deserbed, we shall be more eager to tell others of the advantages of the insurance."

Direction to Pay Forms

The committee on extension of insurance for the Wisconsin Plan reports that direction to pay forms may be obtained from any participating insurance company. When the patient signs this form, he indicates that he is within the eligible income group and directs payment of benefits to the physician in accordance with the schedule of benefits.

Use Plan Terminology

The committee emphasized that physicians should provide a full explanation of services rendered when the statement is submitted. It is suggested that the terminology appearing in the schedule of benefits be used whenever possible. If a Wisconsin Plan patient is over the income level of the plan, the doctor is not committed to the benefit provided, but that benefit will apply against the doctor's total charge.



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STATE ANESTHETISTS SPONSOR MEETINGS AND SPEAKERS BUREAU

Racine, April 28.—One of the most active state groups of anesthesiologists in the country is the Wisconsin Society of Anesthesiologists, the third such group to form a component chapter of the national society.

The part-time physician anesthetist, or the doctor in a small hospital who combines anesthesia with general practice and surgery is receiving the attention of the state group by being invited to participate in a series of short courses in anesthesia.

The first course was held in Milwaukee on April 11. The second will be held in Madison, May 23, on the subject of "The Respiratory System in Anesthesia." Other courses are planned on "ether" and "nitrous oxide and ethylene."

The Wisconsin Society is also making a determined effort to explain the aims and proper uses of the doctor anesthetist to hospitals, nurses and the public. Part of this program is being augmented by the organization of a speaker's bureau whose services will be offered to any group desiring a discussion of current topics in anesthesia.

WISCONSIN PHYSICIANS SERVICE GAINS FROM SUCCESSFUL BLUE CROSS DRIVES

1948 Premium Income May Exceed Half Million

Madison, April 28.—Physicians and hospitals have been giving their wholehearted support to the extension of Blue Cross and Wisconsin Physicians Service coverage to Wisconsin citizens during recent "Blue Cross Weeks" in several state communities, reports Mr. Ralph F. Weber, director of Wisconsin Physicians Service (WPS).

During week-long Blue Cross drives in Racine, Kenosha and Barron counties, the doctors and hospital administrators have greatly aided the effort to help more Wisconsin people budget the costs of hospital and surgical care, he said. Blue Cross acts as salesman for WPS.

Mr. Weber pointed out that the success of a drive in Barron county last month was due in large part to the cooperation of the county medical society and the hospitals in interpreting Blue Cross and WPS to the public. Preliminary reports indicate that Blue Cross enrolled more than 350 families in the county and that WPS made similar gains.

A Kenosha newspaper, commenting on the Blue Cross week held there March 22–27, said that Blue Cross was established as a result of a study made to find ways for the average family to budget hospital care.

"A similar study by medical leaders in the state resulted in Wisconsin Physicians Service, the surgical companion to the hospital plan. Wisconsin Physicians Service is sponsored by the State Medical Society.

"That is why the Blue Cross makes payment directly to the hospital. In the case of the surgical plan, the medical plan makes payment directly to the doctors.

"Wisconsin Blue Cross plan and the Wisconsin Physicians Service plan are simply the non-profit agencies for putting these agreements into effect."

Mr. Weber also announced a quarterly report on the growth and financial standing of WPS. He said that, as of March 31, WPS had 23,598 contracts in effect with 55,691 persons covered. Benefits paid in the first quarter of 1948 totaled $79,659.25. Total premium income during the period was $118,927.30. It is estimated that the total premium of WPS for 1948 will exceed half a million dollars if the current rate of enrollment continues.

CIO Appoints Group to Push Health Plans

Want Five Cents for Health

Detroit, April 29.—Formation of a UAW–CIO health and medical care advisory committee as a major move in the union's five-cents-for-health drive was announced recently. The news was made public by Emil Mazey, secretary-treasurer and acting president of the UAW–CIO in the absence of Walter Reuther, president.

The new body of authorities on every phase of public and group health and medical care will advise the union's social security committee and the Social Security Department on matters related to the Union Health and Medical Care program, the UAW–CIO announced. This program includes a demand for five cents per hour per worker for hospitalization, health, medical and surgical services.

The following medical men have accepted appointment to the committee: Dr. George Baehr, president of the New York Academy of Medicine and clinical director of Mt. Sinai Hospital, N. Y.; Dr. Frank Weiser, director of research of Grace Hospital in Detroit; Dr. F. D. Mott, chairman, Health Services Planning Commission, Regina, Saskatchewan, Canada; Dr. Dean Clark, medical director, Health Insurance Plan of Greater New York; Dr. Basil MacLean, director, University of Rochester, Strong memorial Hospital;

Dr. John P. Peters, professor of clinical medicine of Yale Medical school, and secretary of the Committee of Physicians for the Improvement of Medical Care, Inc.; Dr. Ernest L. Stebbins, director, Johns Hopkins University School of Hygiene and Public Health; Miss Katherine Faville, dean, College of Nursing, Wayne University, Detroit, and Miss Ethel Cohen, director of medical social services, Beth Israel Hospital, Boston.

Dr. Mott is an ardent supporter of compulsory health insurance plans such as the one he directs in Saskatchewan and Dr. Clark has repeatedly voiced the need for government subsidy in prepayment medical plans.

The UAW–CIO reports that this committee will be concerned with the problems of disability insurance, pensions, retirement programs, death benefits and related social security provisions. All are part of the current economic demands of the union.

Premium Income from Health and Accident Coverage Up 18% in 1947

Premium income for 1947 increased nearly 18% over previous years in the accident and health-insurance field, declares H. R. Gordon, managing director of Health and Accident Underwriters. A total of $800 million represents all classes of accident and health coverage (both group and individual policies) but does not include Blue Cross or medical service plan premium incomes.

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References furnished on request.

Name Special Medical Society Committee to Aid Legislative Study of Board of Health

Madison, April 26.—The State Medical Society has announced the appointment of a special committee requested by the legislative council for a study of the structure, organization and responsibilities of the state board of health.

Members of the committee are Dr. Carl D. Neidhold, Appleton. president of the Appleton board of health for 14 years; Dr. H. Kent Tenney, Madison, associate professor of pediatrics at the University of Wisconsin; Dr. W. W. Bauer, Chicago, director of the bureau of health education of the American Medical association, and Dr. Gaylord W. Anderson, Minneapolis, Mayo professor and director of the Minnesota school of public health.

Drs. Neidhold and Tenney represent the practicing physicians of Wisconsin. Both have long acquaintance with state problems and are prominent in State Medical Society activities. Dr. Bauer is a former health commissioner of Racine and his bureau provides consultation services to medical, public health and governmental agencies. Dr. Anderson is an expert in public health administration having served with the administrative practices committee of the American Public Health Association for many years.

Martin W. Torkelson, Madison, state planning engineer, has been designated to act as a committee advisor, and a representative of the Northwestern Mutual Life Insurance company, Milwaukee, has been asked to advise the committee on various office procedures and problems.

Dr. R. G. Arveson, Frederic, chairman of the society's council on medical service and public relations, and Mr. C. H. Crownhart, secretary of the state medical society, will serve as ex-officio members of the committee.

The assistance of the State Medical society was requested by Sen. Gordon A. Bubolz, Appleton, chairman of a legislative subcommittee studying the work of state departments. The group will review the administrative setup of the state board of health for the purpose of suggesting recommendations that may further increase the efficiency of this state agency.

Doctors Are Victims of "Spanish Swindle"

Notify Postal Department If Letters Are Received

Madison, April 15.—The "Spanish Prisoner Swindle" is being used on professional people, particularly doctors and dentists, warns M. G. Eberlein, post office inspector.

Letters are being received in this country from Mexican "Spanish Swindle" operators, he said. Investigation shows that the swindlers are selecting names and addresses from "Who's Who in America" and other lists of professional people.

A copy of the letter currently being used by these swindlers follows:

Mr. Johnathon A. Doe
St. Edward, Nebr.
U. S. A.

Dear Sir:

A person who knows you and who has spoken very highly about you, has made me trust you a very delicate matter on which depends the entire future of my dear daughter, as well as my very existence.

I am in prison, sentenced for bankruptcy, and I wish to know if you are willing to help me to save the sum of $375,000.00 U. S. Cy. (THREE HUNDRED AND SEVENTY FIVE THOUSAND DOLLARS) which I have in bank bills hidden in a secret compartment of a trunk that is now deposited in a Customhouse in the United States.

As soon as I send you undeniable evidence, it is necessary for to come here and pay the expenses incurred in connection with my process so the embargo on my suitcase can be lifted, one of which suitcases contains a baggage check that was given to me at the time of checking my trunk for North America and which trunk contains the sum above said. To compensate you for all your trouble, I will give you the THIRD PART OF SAID SUM.

Due to serious reasons which you will know later, please reply via AIRMAIL. I beg you to treat this matter with the utmost reserve and discretion. Fearing that this letter might have gone astray and not reach your hands, I will not sign my name until I hear from you, and then I will entrust you with all my secret. For the time being I am only signing "M."

Due to the fact that I am in charge of the prison school, I can write you like this and entirely at liberty.

I cannot receive your reply directly in this prison, so in case you accept my proposition, please airmail your letter to a person of my entire trust who will deliver it to me safely and rapidly. This is his name and address:

Sr. Jose Cueto
Calle de Donceles No. 40 "M"
Mexico City, Mexico

In event such a letter is received, or any member has been victimized, the Post Office Department should be notified. Write to Post Office Inspector, Madison 1, Wis.

Replies to the "Spanish Swindle" letter usually result in a three-page letter together with fake newspaper clippings and legal papers intending to substantiate the story and arrange for receipt of the victim in Mexico.

EXPAND MILITARY MEDICAL TRAINING

Washington, D. C., April 1.—A revised and expanded professional training program for regular army and reserve medical officers was announced recently by Major Gen. R. W. Bliss, surgeon general of the army.

The program calls for 1,900 new doctors in the regular army and an increasing number of volunteer reserve officers on active duty. The new program is designed to allow the medical corps to assign professional officers to posts where they can practice in their special fields of interest.

Five major aspects of the program are:

1. Physicians already resident in civilian hospitals are eligible for commissions in the regular army and may continue residencies with full pay and allowances from the army.

2. Civilian interns may receive reserve corps commissions and may continue internships with full pay and allowances.

3. This year 500 younger doctors will be commissioned and assigned to duty at army hospitals to compete for 260 residencies in both army and civilian hospitals.

4. Three hundred commissions to grades of major, lieutenant colonel and colonel will be offered in 1948 and 1949 to doctors who have completed their training.

5. Active reserve service for specific positions and limited periods will be offered to doctors not interested in a regular army career.

This program has been presented to the Council on Medical Education and Hospitals of the AMA and to the AAMC, and both have recognized its value, Dr. Bliss stated.

The First Annual Series of
SECRETARIES' CONFERENCES

MAY 26	MAY 27	JUNE 2	JUNE 3
Hotel Retlaw	Legion Hall	Hotel Wausau	Hotel Land O' Lakes
FOND DU LAC	BARABOO	WAUSAU	RICE LAKE

THE CONFERENCE

While these meetings are designed primarily for officers and committee chairmen of county medical societies, delegates and councilors, all members of the State Medical Society of Wisconsin are invited to attend. The subjects under discussion will be of interest to all physicians. The Council on Medical Service and Public Relations is sponsoring these conferences to bring about a better understanding and closer acquaintance with society activities, medical economic affairs and public relations practices within the profession.

FREE! No registration fee is required. All who attend will be guests of the State Medical Society, but it is important that you inform us if you plan to attend, as hotels require advance reservations.

THE PROGRAM

Opens at 4 p. m. with remarks by R. G. ARVESON, M. D., Frederic, chairman, Council on Medical Service and Public Relations.

VETERANS — 4:10 p. m.—"Federal and State Medical Care of Veterans"
MR. THOMAS J. DORAN, director, Wisconsin Veterans Medcial Service Agency of the State Medical Society
MR. FRED MOTT, Wisconsin State Department of Veterans Affairs

PUBLIC RELATIONS — 4:50 p. m.—"The County Medical Society and Medicine's Public Relations"
MR. LAWRENCE W. REMBER, executive assistant, coordination and Public Relations, American Medical Association

DINNER — 5:30 p. m.—Participants will be guests of the State Medical Society

COUNTY SOCIETIES — 7:00 p. m.—"The State Medical Society and Its County Societies"
W. D. STOVALL, M. D., president, State Medical Society

BOARD OF HEALTH — 7:20 p. m.—"The State Board of Health and Medical Societies"
C. N. NEUPERT, M. D., State Health Officer

THE SMS — 7:45 p. m.—"Outlook for Tomorrow"
MR. C. H. CROWNHART, secretary, State Medical Society

DETACH—PASTE ON PENNY POSTAL—MAIL TODAY

Register Now →

R. G. Arveson, M. D., Secretaries' Conferences
State Medical Society
917 Tenney Building, Madison, Wisconsin
Dear Dr. Arveson:

Please register me for the Secretaries' Conference to be held at _____

_____

Fond du Lac __ May 26
Baraboo _____ May 27
Wausau _____ June 2
Rice Lake ____ June 3

Signed _____
Street _____
City _____

Raise Salaries for Public Health Workers; Earn-While-You-Learn Plan for Physicians

Madison, May 1.—A legislative study of the state departments has resulted in the complete upward revision of salaries for public health personnel in Wisconsin.

The survey was made by the legislative interim committee on reclassification, an advisory committee of the heads of nine state departments, the bureau of personnel and four special consultants in the field of personnel work. The new pay schedules take into account the current market value of the various salaries based on training, experience, incomes of doctors in private practice, similar positions in other states and industry and a complete re-writing of all specifications for the jobs.

Salaries for public health physicians now range from $430 to $605 per month. Effective July 1, 1948, this range will increase to $545 and $785 per month.

Public Health Engineers formerly had a range of $220 to $455, but on July 1 will increase to $290 to $590. The State Sanitary Engineer now has a range of $455–$555 and will increase to $580–$685.

Public Health Nurses ranges from $190 to $380, but on July 1 will go to $230–$525. Public Health Educators who formerly had a $240–$290 classification will now be able to get $270–$445.

Public Health Dental Hygienists have had their salary ranges increased from $230–$290 to $290–$345. Nutritionists formerly had a $220–$320 classification, but will now range from $270 to $445.

The assistant state health officer and heads of the sections of the state board of health will have a $670–$785 pay range. District health officers have a $545–$645 range; the director of the bureau of public health nursing will be in the $445–$525 range; her assistant and the consultant nurses will get $375–$445, and demonstration nurses loaned to local units may receive from $230 to $325.

The major purpose of the revised pay schedule is to enable the board of health to retain its present personnel and to help fill vacancies that have occurred as a result of salary discrepancies. Four out of nine district health officer positions are vacant as are the directorships of the divisions of tuberculosis and venereal disease control.

Candidates .for these positions must have graduation from a Class A medical school; licensure or eligibility for licensure in Wisconsin (including at least one year of accredited internship), and graduation from at least a year's course in public health administration in a recognized school of public health.

Under an emergency program with the U. S. Public Health Service providing funds, the State Board of Health can now employ young Wisconsin physicians who are interested and capable of development at a salary of $500 per month while they get experience and acquaintance with public health problems, Dr. C. N. Neupert, state health officer, reports.

The USPHS would then sponsor a year's training in a recognized school of public health on a stipend of $360 per month for a physician with a family, Dr. Neupert declared. He said this was a move to meet an emergency situation in which there are no trained public health personnel available and any strengthening of the ranks means recruiting and training the men.

"After Doctors Are Socialized Then Come Editors?"

The same society that imposes socialized medical practice upon doctors will not immunize newspapermen from infection with the virus of state regimentation, warns John F. James, editor of the *Johnstown (Pa.) Democrat*, according to a story in *Editor and Publisher* magazine of April 10, 1948.

James made this observation the theme-paragraph of a speech delivered before medical men assembled at Harrisburg, Pa., March 18. James, now a newspaperman, was a pharmacist's mate in the U. S. Navy.

The evils of mass medicine, he said, include "bureaucratic inefficiency, crass professional politics, military emphasis upon rank with its relegation of skill to a secondary position, the discouragement of initiative and enterprise, submersion of personal achievement, bureaucratic red tape, and the imposition of the rigid framework of the caste system."

"As students of human nature, you gentlemen are aware that frequently it is not the facts and the truth that govern, but what people believe — often mistakenly — to be the facts and the truth," James warned his listeners.

He went on, then, to expound his thesis that it is up to the doctors to tell their story, so that the public can appreciate the doctors' limitations and the forces affecting their availability. He also recommended news releases from local medical associations.

Establish Cooperative Hospital Plan in Duluth

Outline Benefits and Cost; Doctors to Be Employed

Duluth.—A cooperative hospital, known as Arrowhead Health Center, is to be opened this year in West Duluth, Minn., under joint ownership of CIO, AFL and Railroad Brotherhood members, states a recent issue of the *CIO News*.

Run by an 11-member board of trustees, the cooperative is purchasing a hospital for $100,000. The trustees hope to sell life memberships in the corporation to at least 2,000 families at $100 per membership. Membership campaigns are under way in most CIO locals.

Details of the medical services available to each family and what it will cost them over and above the $100 membership fee are not yet complete. Plans call for hospital care for as many as 75 days per year, according to the *News*. Hospital services including x-ray, physical therapy, laboratory services and operating room charges will be provided to some extent.

"Free medical care" will be provided whether hospital care is needed or not, the *CIO News* reports. The plan covers the cost of a ward bed to any member of a family enrolled. Semi-private or private rooms will cost extra.

Costs of the plan will be about $2.50 a month for a single person; about $5 for a family of two and about $6 for a family of three or more. The doctors and hospital administrators will not own the hospital, the *News* stated, "they will be employees of the people who need the services. If any surplus funds accumulate they will belong to the members and not to the doctors or the hospital."

(Continued from page 498)

through a system of free choice of physician, utilizing the existing clinics for pension examinations and pension purposes. Mr. Doran indicated that General Hawley is reflecting the feeling of the average veteran, who resents being cared for through the Veterans Administration facilities and would prefer to deal directly with his family physician. However, there seems to be a growing tendency on the part of the Veterans Administration to assume responsibility for the extension of the program by providing facilities for the nonservice-connected disability case as well as the service-connected disability case. Mr. Doran reported that this growing tendency on the part of the Veterans Administration to expand its facilities beyond the area of the service-connected disability field was causing considerable concern to the American Medical Association, and its committee on veterans affairs is planning to meet with General Hawley and the medical advisory group of the Veterans Administration to establish a policy which would carry out the intent of the home town medical care program. At the conclusion of Mr. Doran's report, Doctor Truitt asked whether any of the money which had been loaned to the Veterans Medical Service Agency had been repaid. Mr. Doran replied that no repayment had been made but that $9,500 is in the revolving fund of the Veterans Medical Service Agency and it is the recommendation of the operating committee that as soon as this fund has been increased to a total of $10,000 the agency would repay to the State Medical Society a sum of $5,000 on the original loan of $15,000. Doctor Witte asked Mr. Doran what percentage of the authorization had been paid to Milwaukee physicians. In reply Mr. Doran indicated that on the first $100,000 worth of business Milwaukee secured approximately $17,950 of this sum, and that of the first $200,000 worth of business the total received by Milwaukee physicians was $29,127. Mr. Doran presented a map showing the extent of the services on a county basis, indicating that the 25 counties in the lower half of the state had received 62 per cent of the cash of the entire program to date. Following Mr. Doran's presentation Doctor Supernaw commented briefly on the fact that in a recent conference in St. Paul where reports of the various veterans medical service programs were presented, it was evident that Wisconsin had one of the best programs in the entire country. He called special attention to the fact that Wisconsin physicians have given ample evidence that they are not "chiseling" on the Veterans Administration program, and that in many instances they are not billing the agency for the entire amount allowed on the schedule. At the conclusion of Doctor Supernaw's statement, by motion of Doctors Arveson and Dessloch, the Council unanimously commended the agency and the operating committee for the efficient conduct of the agency's affairs.

6. Interim Report of the Wisconsin Physicians Service

Before Mr. Weber was introduced to give a detailed explanation of the financial statement of the Wisconsin Physicians Service, Doctor Vingom spoke briefly as to the development of the program and the pleasure of the operating committee in working with Mr. Weber as director of the plan.

Mr. Weber's report indicated that at the time of the Council meeting 1,839 Wisconsin physicians were participating in the program and that 267 separate groups had been covered as of September 30, representing a total of 12,156 contracts with 28,080 participants in the program. A total of 423 physicians had rendered service under the plan up to that date, September 30, and the service benefits totaled $31,787.50. On the basis of experience to date Mr. Weber estimated that there would be a total of 337 groups covered as of December through the end of the year with an estimated coverage of 40,479 persons covered. Projecting the report through December 1, Mr. Weber indicated that the extent of coverage as of December 1 was $48,090.50, and on the basis of anticipated business the total for the end of the year would be in the neighborhood of $78,090. This would represent the total amount of service benefits paid under the program. Turning to the anticipated premium income, Mr. Weber indicated that approximately $126,550 would be paid into the plan by the end of the year. Describing in detail the administrative cost of the program to date, Mr. Weber indicated that the deficit as of September 30 totaled $10,810.46, but that on the basis of business during the past several months it was estimated that the program would soon be in "the black." Following an explanation of the finances in operating the agency to date, Mr. Weber described the sales activities and the relationship of the program to Blue Cross. Procedures in operation of the plan were described indicating the relationship between the Milwaukee office and the administrative office in Madison. Following the report of Mr. Weber, Doctor Truitt raised the question as to the propriety of discontinuing the services of one of the employes of Wisconsin Physicians Service. After discussion of the actions which led to the dismissal, it was the vote of the Council that the matter should be dropped and no further action taken.

7. Report of the Interim Committee

Doctor Stovall, speaking for the Interim Committee, reviewed briefly the two meetings of this committee and their work of reviewing office procedures and becoming better acquainted with details of the annual budget. He presented the report merely as an account of progress, stating that the committee intended to become better acquainted with all activities of the central office and would be prepared to present a more complete report to the Council at a later date.

8. Interim Report of the Wisconsin Plan

Dr. H. H. Christofferson described to the Council the problems confronting the further development of the Wisconsin Plan, mentioning specifically the fact that insurance companies were questioning the advisability of writing a uniform policy, as such action might subject them to certain features of the Sherman Anti-Trust Law. Doctor Christofferson stated that efforts were being made to reconcile the fee schedule of the Wisconsin Plan with the fee schedule of the Wisconsin Physicians Service. He reviewed the history of the development of the Wisconsin Plan and the fact that in its initial stages the large eastern companies were not particularly interested in the development of this type of insurance coverage. But now that the plan has operated successfully many of these eastern companies have evidenced an interest in further participation. As a means of making the operation of the Wisconsin Plan more effective it had been suggested by the insurance companies that the Conference Committee be enlarged to a membership of seven physicians. This Conference Committee would review and accept policies that comply with the minimum standards as set up by the State Medical Society through its committee on insurance, and the Conference Committee would also review and pass upon surgical procedures covered by the insurance program. In describing the further development of the Wisconsin Plan, Doctor Christofferson called attention to the fact that many other states are beginning to develop programs of like character, and he felt that this was ample evidence that utilization of the insurance companies for the development of voluntary sickness insurance plans was a logical and desirable approach to the problem of providing adequate care for the large mass of people in the United States on a voluntary basis. He expressed particular interest in the development of these programs, particularly the Wisconsin Plan, through the agency of the Farm Bureau in Wisconsin. Doctor Christofferson described the activities of the Farm Bureau in making the Wisconsin Plan available to the members of this large farm organization with a potential coverage of 121,000 farmers in Wisconsin alone.

9. The Wisconsin Rheumatism Association

Mr. Crownhart explained to the Council that at the suggestion of the Interim Committee the Wisconsin Rheumatism Association was invited to send one of its members to appear before the Council to discuss the purposes of the organization and their scientific program inasmuch as the organization had suggested that the State Medical Society might wish to assist them in the development of their program by way of a financial contribution. The secretary reported that Dr. C. C. Edmondson, Waukesha, secretary-treasurer of the Wisconsin Rheumatism Association, had been invited to attend the Council meeting, but he was unable to do so, and in view of this fact the Council might wish to hold this matter open until a later meeting. Doctor Truitt, speaking in behalf of the Interim Committee, concurred in the suggestion that the matter be laid aside for consideration at a later Council meeting.

10. Life Membership

The secretary discussed with the Council the problem which has arisen as a result of recent action of the House of Delegates relative to life membership in the State Medical Society. To refresh the memory of the Council he reviewed the constitution and by-laws which provide that a physician who has been continuously a member of a county medical society and the State Medical Society for fifty years, or who has reached the age of 80 and has been continuously a member is eligible for life membership in the State Medical Society. Mr. Crownhart indicated that under the by-laws as they existed prior to the 1947 session of the House of Delegates it was not a condition that such a member be a member of the State Medical Society of Wisconsin to qualify for life membership. After action on this matter had been taken by the House of Delegates, the secretary sought an interpretation of the wishes of the reference committee by corresponding with Doctor Trumbo, who was chairman of the reference committee, considering the matter of life membership. Doctor Trumbo reported to the reference committee as follows: "The committee is mindful of the honor and distinction that is due long time membership and service in the State Society and feels that recognition for this service should be given. Therefore, it recommends that the appropriate by-law be amended and that life membership be extended to the members who are 75 years of age and who, since beginning the practice of medicine, have been continuously members of the State Medical Society or who for forty continuous years have been members of the State Society." The secretary indicated that this action of the reference committee appears to have direct reference to the State Medical Society of Wisconsin, and in order to clarify the feelings of the reference committee on the problem he again contacted Doctor Trumbo, who stated: "It was the final thought as I remember that a life membership grant should apply only to our own State Medical Society members and not to those who moved in from other states: forty years a member of the Wisconsin State Society or 75 years of age and a member since starting the practice in Wisconsin." Mr. Crownhart further checked with the secretary who served the reference committee during the last meeting of the House of Delegates and it was her recollection that the rule was to apply to residents elsewhere as well as residents in the state. Mr. Crownhart indicated that the Council was being requested to express its interpretation of the will of the House of Delegates as to whether the amendment to the by-laws simply changed the age qualification that now exists or whether the amendment is to be construed so that it

would require continuous membership in Wisconsin before a physician qualified for life membership in the State Medical Society of Wisconsin. It was the feeling of Doctor Gavin that there should be some limitation placed upon the application of this rule so that a physician who had practiced for many years outside of the state and few years as a physician in Wisconsin might qualify for life membership in the State Medical Society of Wisconsin unless the Council clearly interpreted the amendment to the by-laws in such a way as to prevent life membership being granted to a physician under the circumstances described. Following further discussion, it was moved by Doctors Christofferson and Dessloch that the Council record its action as providing that a physician is ineligible for life membership in the State Medical Society of Wisconsin unless he meets the qualifications of continuous membership in Wisconsin for forty years. This action was approved by the Council without a dissenting vote.

11. Annual Meeting Arrangements

Doctor Doege, appearing for the Council on Scientific Work, discussed with the Council the problem of maintaining attendance at the annual meeting so that the concluding session on Wednesday afternoon would not be poorly attended. It was the suggestion of the Council on Scientific Work that possibly interest in the meeting could be sustained if the annual banquet was held on Wednesday evening instead of Tuesday evening, as has been the practice during the past several years. The Council on Scientific Work asked that the main Council of the State Medical Society consider this as a possible change in arrangements and make its recommendations to the Council on Scientific Work so that the annual meeting arrangements could be made in conformance with the Council of the State Medical Society. It was the consensus of the Council that it would be best to leave the arrangements as heretofore, with the annual dinner being held on Tuesday evening rather than on Wednesday as suggested by the Council on Scientific Work. Mr. Ragatz outlined the plan of the Council on Scientific Work in presenting a series of clinical conferences on the opening day of the meeting rather than having a general scientific session. This plan was approved by the Council without a formal vote being taken.

12. Section Appropriation

Mr. Crownhart reviewed the problem, stating that some of the sections have been put to considerable expense in providing exhibits at the annual meeting, and it was suggested that a policy be established of granting $25 annually to each of the four recognized sections for necessary expenses in stenographic help, etc. He indicated that the Section on Radiology had suggested that the original allotment of $25 was inadequate in view of present day costs and suggested that this annual allotment be increased to $50 for each of the four approved sections and others that are approved at a later date by the Council or the House of Delegates. By motion of Doctors Leahy and Witte, the Council voted to appropriate a sum of $50 for each of the four recognized sections for the next year only.

13. Certificate of Election

The secretary indicated that a suggestion had been passed on to him that the central office provide a formal certificate of election to all those who are subject to general election by the House of Delegates. It was suggested that an appropriate certificate be provided so that it would be suitable for framing and that the certificates would be sent to all officers elected at the time of the House of Delegates. It was estimated by Secretary Crownhart that the total cost of providing an adequate supply for a twenty-five year period would not be in excess of $25. By motion of Doctors Arveson and Hemmingsen, the Council approved of the suggestion and directed the secretary to provide a suitable certificate of election to all officers elected by the House of Delegates. This would also include American Medical Association delegates elected by the House.

14. Resolution of the Section on Radiology

Mr. Crownhart presented the following resolution as submitted to him through the Section on Radiology:

WHEREAS the practice of radiology has been repeatedly defined as a medical service, and

WHEREAS in previous Blue Cross contracts diagnostic roentgenology was grouped separate from hospital services, and

WHEREAS in the present Blue Cross contracts x-ray is included in the list of hospital services rendered,

Be it Resolved, that:

1. The Associated Hospital Service organization be earnestly requested to return diagnostic roentgenology to its previous listing separate from hospital services, and
2. That Milwaukee Surgical Care and Wisconsin Physicians Service, and Associated Hospital Service be earnestly requested to seek the transferral of all radiologic services from Blue Cross contracts to Surgical Care and Wisconsin Physicians Service contracts at the earliest possible date, and
3. That a copy of this resolution be transmitted to the Milwaukee Surgical Care, Wisconsin Physicians Service, and Associated Hospital Service, to the Wisconsin State Medical Society and the Milwaukee County Medical Society, and to the American College of Radiology.

Mr. Crownhart suggested that it might be well to establish a procedure whereby sections would not publicize resolutions before transmitting them to the Council of the State Medical Society for consideration. After further discussion of the various problems involved it was agreed that the matter should be referred to the Council on Medical Service and

Public Relations. The secretary called attention to the fact that the scientific sections of the Society which have been approved according to Section 5 shall not have the power to bind the Society by any resolution or other action, or to publicize the same unless the matter has first been approved by the House of Delegates or by a majority of the members of the Council when the House is not in session. He suggested that it might be proper to have the Interim Committee direct a communication to the four sections calling their attention to this provision of the constitution and by-laws so that this procedure would be followed in any future situation. By motion of Doctors Witte and Ekblad, the Council concurred in this suggestion.

15. Life Membership of Dr. R. C. Buchanan, Green Bay

The secretary reviewed the situation which prompted his placing this matter on the agenda. He stated that the records of the State Medical Society were rather inadequate during the early days of the Society, and as a result he was not able to verify except through a telephone conversation the fact that Doctor Buchanan was eligible for life membership in the State Medical Society. By motion of Doctors Dessloch and Arveson, the Council voted Doctor Buchanan a life member of the State Medical Society.

16. Relative to Providing More Bed Capacity for the Mentally ill

Doctor Christofferson called the attention of the committee to the deplorable situation which exists in the state relative to the housing of the mentally ill. He indicated that during the past seventy-two years very little has been done to improve the bed capacity for the mentally ill with the exception of providing two small receiving institutions in Oshkosh. He reported that the Committee on Mental Hygiene and Institutional Care had met several days prior to the Council meeting and requested that he appear before the Council asking the Council to appoint a committee of three to formulate a letter to the governor urging the release of a portion of the funds which had been provided by the legislature for immediate construction or remodeling of the building program at Oshkosh. Because funds which had been appropriated by the legislature for specific construction were inadequate to provide the building program contemplated by the legislature, these funds were remaining idle, and it was the feeling of the Committee on Mental Hygiene and Institutional Care that a portion of these funds should be released immediately for rehabilitation of the mental hospital at Oshkosh. Doctor Gavin appointed Doctors Christofferson, Arveson, and Witte to serve as a committee of three to consult with the secretary as to the type of letter which should be drafted and sent to the Governor urging the release of funds for the construction of needed rehabilitation of the mental institution at Oshkosh.

17. Appointment of a Committee to Study and Recommend Health and Accident Policies

The secretary stated that this matter had been held over on the agenda since August 1947, and if it was agreeable to the Council the matter would be referred to the special committee appointed to make such recommendations to the Council. By motion of Doctor Arveson and seconded generally the Council so approved the suggestion of Secretary Crownhart.

18. Support of the Shearon Medical Legislative Service

The secretary reported on the work being done by Miss Marjorie Shearon, Washington, D.C., in disseminating valuable information on the activities of Communists and Socialists and all other similar type of individuals who are supporting programs comparable to the Wagner–Murray–Dingell Bill. Mr. Crownhart outlined some of the valuable information that Miss Shearon has released which has been of value to organized medicine, and it was suggested that the work of Miss Shearon be given encouragement by having the Council approve of the purchase of subscriptions to her legislative service. It was suggested that for an appropiation of somewhat less than $275 the legislative service could be supplied all councilors and essential committee chairmen, especially those in the legislative field. By motion of Doctors Arveson and Wilkinson the Council approved unanimously the suggestion that this service be provided all councilors and selected committee chairmen, especially those interested in matters of medical economics.

19. Participation in the Harper Memorial Celebration

The secretary outlined for the benefit of the Council plans of the State Board of Health in providing a Harper memorial dinner to honor Doctor Harper upon his retirement from state service It was suggested by Mr. Crownhart that the Council might wish to give encouragement to this memorial event by sponsoring a reception for all those in attendance at the dinner. He estimated that the cost of the reception would not exceed $500 and would probably be less. By motion of Doctors Wilkinson and Truitt the Council approved the suggestion that the secretary would be authorized to make arrangements for a suitable reception to be held prior to the Harper memorial dinner and that the Council of the State Medical Society would serve as hosts at the reception. The motion was carried unanimously.

20. Adjournment

There being no further business to come before the Council, the meeting was adjourned at 6:05 p.m.

C. H. Crownhart
Secretary

Approved:

S. E. Gavin, M. D.
Chairman of the Council

Minutes of the Council Meeting, Madison, January 31, 1948

1. Call to Order

The Council was called to order by Chairman Gavin at 4:30 p.m., Saturday, January 31, 1948 at the Hotel Loraine, Madison.

2. Roll Call

Councilors present were Doctors Wilkinson, Hemmingsen, Vingom, Dessloch, Heidner, Gavin, Fox, Bell, Chirstofferson, Arveson, Ekblad, Witte, Fitzgerald, Truitt, and Past-President Dawson.

Also present were President Stovall, President-Elect Doege, and Secretary Crownhart.

3. Recess

Following a discussion of the business to be conducted at this session, the Council recessed to act as hosts at the Harper memorial dinner.

4. Call to Order

The Council reconvened at 9:00 a.m., Sunday, February 1, 1948, at the Heidelberg Hofbrau, Madison. Chairman Gavin called the meeting to order.

5. Roll Call

Same as above.

Also present were Drs. J. S. Supernaw, I. R. Sisk, Gunnar Gundersen, L. V. Littig, W. T. Clark, S. L. Henke, and J. S. Sargent; Mr. Walter Gehrke, investigator, State Board of Medical Examiners; Assistant Secretary Ragatz; Mr. R. F. Weber, director, Wisconsin Physicians Service; Mr. T. J. Doran, director, Wisconsin Veterans Medical Service Agency; Executive Assistant Thayer; and Miss Kracht.

6. Councilor District Reports

Doctor Wilkinson, reporting for the First Councilor District, emphasized the fact that membership within the councilor district has increased. He stated that in attending the county society meetings he observed some problems which he felt should come to the attention of the Council. He specifically mentioned misunderstanding of the re-registration fee. Another criticism he observed in his councilor district is the fact that hospital standardization is in the hands of too many different agencies and that standardization is not uniform.

Doctor Hemmingsen, reporting for the Second Councilor District, stated that no district meeting as such had been held, but that the component county societies had been holding their regular meetings. He stated that in the second district a section on general practice has been formed.

Doctor Heidner reporting for the Fifth Councilor District, stated that several of the component county societies were trying a special type of scientific program whereby any physician in the county can bring in patients and the physicians in attendance spend an entire afternoon at one of the hospitals as a sort of postgraduate clinic. He reported an increase in membership throughout the component societies and stated that in the main the physicians in his councilor district were enthusiastically cooperating with the development of the various insurance programs. He cited one exception by reading a letter from a physician in Calumet County objecting to the general fee structure of the insurance plans being advocated by the State Society.

Doctor Gavin, reporting for the Sixth Councilor District, stated that his councilor district has had a number of highly successful meetings from the standpoint of both the scientific programs presented and the high interest of those in attendance.

Doctor Fox, as the newly elected councilor from the Seventh Councilor District, reported briefly on the activities of the La Crosse County Society and the meetings of the Trempealeau–Jackson–Buffalo County Society. He stated that he would devote considerable time in the ensuing year to the stimulation of county society activities in his councilor district.

Doctor Bell, the new councilor for the Eighth Councilor District, reported that he was planning a district meeting sometime in May and he hoped to stimulate considerable attendance for that joint meeting of the component county societies.

Dr. H. H. Christofferson, councilor for the Ninth Councilor District, reported four regular councilor district meetings during the year. He stated that in addition to the regular councilor district meeting a special meeting is annually held, with the county presidents, secretaries, delegates, and alternates meeting with the councilor a month or six weeks prior to the annual meeting to discuss various matters which will be brought before the House of Delegates of the State Medical Society. He felt that in this manner the membership within his councilor district is well informed as to Society activities.

Doctor Arveson, reporting for the Tenth Councilor District, stated that within his district there is considerable interest in a cooperative form of health insurance and hospitalization. He stated that the physicians within his district would pay special attention to this problem during the ensuing year.

Doctor Ekblad, reporting for the Eleventh Councilor District, stated that the county societies within his district have met regularly and that they were especially appreciative of having the council meet with them in August 1947.

Doctor Witte, reporting for the three councilors of the Twelfth Councilor District, stated that the

Medical Society of Milwaukee County has met regularly and that attendance at most of these meetings has been very satisfactory. He stated that the physicians have expressed considerable concern over the problem of hospitalization. He reported that the Surgical Care insurance program has grown very satisfactorily and that in the main the physicians seem well satisfied with the operation of the plan.

Doctor Leahy being absent, there was no report given for the Thirteenth Councilor District.

Doctor Vingom reported for the Third Councilor District. He stated that the councilor district meeting held in December 1947 was very well attended and the scientific program appealed greatly to the physicians in attendance. He reported that affairs in the third district seem to be very satisfactory even though there is a marked scarcity of hospital beds.

Doctor Dessloch reported for the Fourth Councilor District that there had not been any regular councilor district meetings held in the fourth district but that he intended to organize such a meeting during the ensuing year.

7. Report of Doctor Dawson as Secretary of the State Board of Medical Examiners

Doctor Dawson reported on the activities of the investigator for the State Board of Medical Examiners, stating that at the present time through the efforts of the investigator practically all of the unlicensed chiropractors have gone elsewhere. He stated that at the present time the investigator was able to locate only three unlicensed chiropractors in the state. Doctor Dawson explained to the Council the general activities of the investigator and the general work that is being done to eliminate the activities of cultists from the state.

8. Report of the Treasurer

Doctor Sisk, in presenting the report of the treasurer for the year 1947, called attention to various sources of revenue tolling $121,000. He spoke briefly on the expenditures, calling special attention to the loan which had been made by the Council to Wisconsin Veterans Medical Service Agency to the extent of $5,000 and Wisconsin Physicians Service to the extent of $10,000 in the year 1947. He also called attention to the special expenditure in the nature of a deposit made on a piece of property tentatively being considered as a permanent home for the State Medical Society of Wisconsin in Madison. His report showed a total expenditure of $116,000 for the year 1947, leaving a net balance of $13,000. Doctor Sisk briefly reviewed the status of government bonds now held by the State Society in total of $42,000. The loan to Wisconsin Physicians Service was discussed with several of the councilors, with Mr. Crownhart giving further information as to the extent of the loan and the anticipated repayment of the entire loan through operation of Wisconsin Physicians Service through the ensuing year. He indicated that at the present time Wisconsin Physicians Service is writing sufficient coverage to carry its own expense and that it is anticipated that the entire loan of $20,000 will be partly repaid during the ensuing year.

The treasurer's report follows:

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

REPORT OF DR. IRA R. SISK, TREASURER
For the Year Ended December 31, 1947

Cash on Deposit—First National Bank, January 1, 1947		$ 8,433.21
Revenues		
Membership Dues	$94,582.46	
1947 Exhibit Space Rentals	9,704.07	
Proceeds from Sale of Securities	9,436.86	
Panel Receipts—Wisconsin Plan	231.70	
Panel Receipts—Unemployment Compensation	40.00	
Roundtable Receipts	3,211.15	
Postgraduate Clinic Receipts	2,392.00	
Interest Received	1,357.28	
Principal Collected on Aetna Insurance Policy	1,004.40	
Total Revenues		121,959.92
Total		$130,393.13
Expenditures		
Constitutional Officers and Committees		
President	$ 500.00	
Council and Committees	5,020.81	
Books and Periodicals	373.90	
Auxiliary	100.00	
Secretary's Salary	9,500.00	
Secretary's Travel	1,884.79	
Group Total	$17,379.50	
Organization Staff		
Assistant Secretary's Salary	$ 6,000.00	
Assistant Secretary's Travel	675.85	
Executive Assistant—Office	3,600.00	
Secretarial Staff	7,799.32	
Group Total	$18,075.17	
Administrative Expenses		
Accounting and Insurance	$ 2,585.62	
Social Security and Unemployment Compensation Taxes	569.68	
Office Rent	1,908.25	
Telephone and Telegraph	1,600.16	
Current Supplies and Light	2,012.20	
Postage and Printing	2,957.27	
Fixtures and Upkeep	720.99	
New Equipment	1,030.31	
Miscellaneous	1,128.56	
Group Insurance	251.10	
Group Total	$14,764.14	
Totals—carried forward	$50,218.81	$130,393.13
Membership—Special Service		
Legal	$ 5,482.27	
Bulletins to Members	633.71	
Blue Book	750.00	
Group Total	$ 6,865.98	
Public Health—Normal Service		
Hygeia	$ 275.00	
Lay Publications	53.25	
Special Bulletins to Members	668.78	
Special Reports in the Journal	7.07	
Telephone and Telegraph	380.84	
Legislative Counsel	2,000.00	
Prepaid Medical Care and Veterans Medic Care	566.27	
Group Total	$ 3,951.21	
Public, Industrial and Rural Health, and Public Instruction		
Executive Assistant	$ 2,500.00	
Executive Assistant's Travel	892.19	
Staff Salaries and Travel	3,301.35	
Assistance, Press and Publicity	1,732.50	
Allocated Office Rent	705.00	
Press Releases	791.50	
Health Exhibits	631.13	
Radio Programs	2,878.33	
Industrial Panels of Physicians	1,714.30	
Group Total	$15,146.30	

Annual Meeting, Postgraduate Clinics, and Wisconsin Medical Journal		
Annual Meeting	$13,644.16	
Postgraduate Clinics	3,708.23	
Wisconsin Medical Journal	3,200.00	
Group Total	$20,552.39	
Other Expenditures		
Advance to Wisconsin Veterans Medical Service Agency	$ 5,000.00	
Advance to Wisconsin Physicians Service	10,000.00	
Deposit of Earnest Money—Paul E. Stark Co.	5,000.00	
Group Total	$20,000.00	
Total Expenditures		116,734.69
Cash on Deposit—First National Bank, December 31, 1947		$ 13,658.44

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

SECURITIES OWNED
December 31, 1947

Description	Interest Rate	Maturity Date	Face Value	Cost
U. S. Government				
U. S. Savings Defense, Series G	2½	6-1-53	$ 2,000.00	$ 2,000.00
U. S. Savings Defense, Series G	2½	6-1-54	6,000.00	6,000.00
U. S. War Savings, Ser. G	2½	9-1-54	3,000.00	3,000.00
U. S. War Savings, Ser. G	2½	6-1-55	5,000.00	5,000.00
U. S. War Savings, Ser. G	2½	1-1-56	8,000.00	8,000.00
U. S. War Savings, Ser. G	2½	8-1-56	5,000.00	5,000.00
U. S. Treasury	2½	9-15/67-72	3,000.00	3,000.00
U. S. Treasury	2½	12-15/67-72	10,000.00	10,000.00
Total Securities Owned, December 31, 1947			$42,000.00	$42,000.00

By motions of Doctors Arveson and Witte the Council accepted an expression of thanks to the treasurer for his services.

9. Report of the Secretary

Scientific and Economic Activities.—The occasion of the secretary's annual report is altogether a pleasant one, for it follows closely upon the beginning of a new year when it is customary to take stock and, at the same time, try to analyze the road ahead. So far as current inventory is concerned, the State Medical Society can well "point with pride." It is successfully carrying out its responsibilities in scientific medicine. Its annual meeting is held by many to be one of the best in the country, and its Journal measures to the same high level. Close working arrangements with the State Board of Health and other groups have enabled the Society to sponsor one of its most successful seasons of refresher and postgraduate clinics in varied fields of medicine and surgery. Its committees in scientific medicine have been active and ingenious as well as devoted to continued promotion of scientific research, studies, and presentations.

In its educational and economic projects, the Society graph of success is most impressive. At the time of writing this report, the two state-wide prepaid medical care programs embrace at least 150,000 persons. It is estimated that the total monthly premium income from these two plans is in the neighborhood of $120,000—or nearly a million and a half dollars annually, of which approximately 80 per cent will be used to pay medical care bills. In another year these figures will be greatly increased.

The Society's program in the home-town care of veterans is admittedly one of the finest in the nation, and through it some half million dollars will be disbursed in medical care bills.

The several committees of physicians which have given devotedly of their time and effort, and the excellent administrative cooperation of the directors, as well as the close interest of councilors and officers, are responsible for the fine record of these agencies. Your secretary wishes to record his personal appreciation of the cooperative attitude that exists on the part of these committee members and their directors in their efforts to promote sound public health measures objectively and effectively. The most exacting critic could not ask more of these men.

Prepaid Plans Medicine's Responsibility.—Your secretary urges continued vigilance in these and other programs of like character. Whatever may be their ultimate achievement, by way of work or planning, it is medicine's ultimate responsibility. A recent medical publication carries an article detailing the opinion of medical men elsewhere as to the effect of current national legislative proposals upon these programs. Men of the same organization differ widely as to the effect of the measure that would subsidize the extension of voluntary plans into the indigent and lower income brackets. One is credited with the remark that he who pays the fiddler usually calls the tune, while another exudes a degree of enthusiasm in welcoming the assistance of Uncle Sam and commits the member plans to the same policy—with such a commitment including one of the agencies of the State Medical Society!

It does not take a crystal ball to sense the implications of some of these programs if they are not within the influence of organized medicine. Your secretary reiterates that which he has expressed before the Council on other occasions, that the economics of medicine must of necessity affect the soundness of scientific medicine—for the preservation and future welfare of the latter organized medicine, through its House of Delegates, its Council and its committees must in itself control the policy and management of these various programs as those programs become endorsed projects of the medical profession itself. The profession need take no responsibility of those situations not of its making nor within its control, but it seems likely that they ultimately, by force of competition must approach the measurement of medicine's own standards if medicine has within its control its own programs.

Time is of the essence—time, and a continuation of interest and devotion that has always characterized the medical profession.

The 1948 Budget.—Turning to more mundane matters, the Council is presented with the responsibility of determining the annual budget. The budget is the product of no one individual. It reflects the action of the House of Delegates in determining certain procedures, and in approving various committee recommendations. Nor is the budget perfect. Probably on the whole it will be underexpended, but its various specified limitations act as a ceiling beyond which no substantial expenditure can be made without referring the problem back to the Council.

There is some talk of dues being too high. The determination of annual dues is the responsibility of the House of Delegates. But the secretary can state without fear of contradiction that the costs of operating an office,without substantial expansion of its personnel, have increased tremendously over comparable costs in 1940 or 1941. The printing cost of the Journal is practically double that of six years ago, and while every effort is made to carry this increase through increased advertising, it is not altogether possible. Journal printing rates are now on a virtually issue to issue basis—yet advertising rates by practice of the trade must be established nine months before becoming operative and are guaranteed for a year thereafter. These are tremendous problems and not susceptible to simple solution.

Society Headquarters.—It appears likely that the Society will have headquarters of its own by the end of 1948. With the rent of the Society almost doubled in recent years, and with the installation of the several agencies in entirely separate quarters, this seems a provident step. But with it will come new problems. Your secretary suggests that the Council consider the possibility of operating its building through an entirely separate account than that used for general purposes. This separate account would receive the rent of the central office and such agencies as are housed in the building, and in that account provision would be made for amortizing indebtedness, creating a cash reserve against depreciation, payment of current operating expenses such as fuel, janitor, and insurance, and the development of any special funds necessary to provide for approved projects such as a library, museum or the like. Your secretary is in accordance with the suggestion that actual management of the building be directed by a special committee of the Council which would have the authority to establish rules relating to its use and care.

Membership.—The Secretary is pleased to report membership status as of December 31, 1947, as follows:

1. Fully paid members	2,631
2. Partially paid members	2
3. Members in service paying no dues in 1947 or dues prorated on discharge or transfer members	93
4. War members who pay no dues	24
5. Resident members who pay $3	140
6. Life, honorary and members whose dues are waived because of temporary but serious incapacity	74
	2,964

The Wisconsin Medical Journal.—The tentative financial statement of The Wisconsin Medical Journal for the year just ended is as follows:

Assets		
American Exchange Bank		$14,714.35
Accounts Receivable—Advertisers		1,036.89
Postage Deposit		66.73
Mailing Envelopes Inventory		75.90
Copyright Deposit		6.00
Other Equipment	$243.75	
Less: Allowance for Depreciation	227.62	16.13
Total Assets		$15,916.00
Liabilities, Reserves, and Surplus		
Current Liabilities		$ none
Reserve for Blue Book Issue		750.00
Surplus, January 1, 1947	$16,011.56	
Deduct: Net Loss for the year	845.56	
Surplus, December 31, 1947		15,166.00
Total Liabilities, Reserves, and Surplus		$15,916.00

TENTATIVE INCOME AND PROFIT AND LOSS STATEMENT

Income		
Advertising		$22,821.82
Subscriptions, Supplements, etc.		294.30
Total Publication Income		$23,116.12
Expenses		
Printing	$19,173.56	
War Records Brochure	467.91	
Salaries	4,672.43	
Cuts	660.60	
Mailing	709.89	
Rent	575.00	
Miscellaneous Expense	127.42	
Supplies	21.25	
Discounts Allowed	46.18	
Accounting Service	360.00	
Social Security Tax	46.75	
State Unemployment Compensation	46.72	
Federal Unemployment Compensation	14.02	
Bad Debt	24.00	
Group Insurance	73.80	
Editorial Expense	140.00	
Depreciation on Office Equipment	2.15	
Total Publication Expense		27,161.68
Publication Loss		$(4,045.56)
Less: State Medical Society Appropriations		3,200.00
Net Loss for the year		(845.56)

Conclusion.—In conclusion, may your secretary express his appreciation for the cooperation and forbearance of the council and officers. He has come to learn the hard way, perhaps, that the interests of medicine are as varied as its membership, but he is increasingly convinced of the right and wisdom of medicine's views in this period of economic upheaval and social readjustments.

May you and your confreres win that fight for the preservation of human rights and freedom—it is your battlefield—and on it your secretary is proud to stand with you and for you in any way he may be of help.

10. Report of the State Board of Health

Dr. Gunnar Gundersen reported for the State Board of Health in the absence of Doctor Neupert. Doctor Gundersen expressed the appreciation of the State Board of Health to the State Medical Society for its part in the Harper celebration the day previous to the Council meeting. Doctor Gundersen spoke of the cordial relationship that exists between the State Board of Health and the State Medical Society. In reviewing the last legislative session, he expressed regret that the legislation sponsored by the State Board of Health for the enlarged facilities for the State Laboratory of Hygiene had not been enacted into law. He felt that this was one piece of legislation which should be pushed during the next session of the legislature. Another activity of the State Board of Health which Doctor Gundersen discussed was the proposed formation of the statewide blood bank through cooperation with the Red Cross, or possibly carrying on the activity as an independent project of the State Board of Health. He made special reference to the need for legislative action in providing more adequate facilities for the chronically ill and the aged. As a representative of the State Board of Health, Doctor Gundersen expressed the hope that the State Board of Health and the State Medical Society would unite their efforts in providing better institutional care for the chronically ill and the aged.

11. Interim Report on the Wisconsin Veterans Medical Service Agency

Doctor Supernaw, as chairman of the Wisconsin Veterans Medical Service Agency Operating Committee, spoke briefly on the development of the program. He stated that the new schedule on radiology and x-ray therapy would soon go into effect. He mentioned several other revisions of the fee schedule originally established and indicated that the revised fee schedule would meet most of the objections which had been raised by physicians who participated in the program originally. Doctor Supernaw then presented Mr. Doran, who gave a more detailed report of the operations of the Veterans Medical Service Agency during the ensuing year. He reported that the total value of authorizations received through the agency up to the end of January was $620,000, with the total value of vouchers sent to the Veterans Administration for payment being $467,000. Mr. Doran reported that the participating physicians seemed very well pleased with the operation of the program and that none of the criticism which had been directed to physicians in other parts of the country as to so-called "chiseling" activities could be directed to Wisconsin physicians participating in the Wisconsin Veterans Medical Service program. In answer to a question from Doctor Truitt as to when the money loaned the Veterans Medical Service Agency might be repaid, Mr. Doran indicated that a repayment could be anticipated sometime within the ensuing year.

12. Interim Report of the Wisconsin Physicians Service

Doctor Vingom, as chairman of the operating committee of the Wisconsin Physicians Service, reported increased coverage through Wisconsin Physicians Service during the ensuing year. He stated that a reconciliation of the fee schedules of the Wisconsin Plan and Wisconsin Physicians Service had been effected and that the program was developing very satisfactorily. He indicated that up to the time of his report Wisconsin Physicians Service had paid approximately $89,000 to physicians participating in the program. Mr. Weber, as executive director of the Wisconsin Physicians Service, gave a more detailed report of the financial status of the agency as well as a report on experiences of service in the various classifications, indicating that the greatest incidence of medical procedures was in tonsillectomies and adenoidectomies, with 433 operations in this category covered by the Wisconsin Physicians Service agency. All other procedures were briefly reviewed for the Council by Mr. Weber. Further discussion was directed to a comparison of the experience of Surgical Care and Wisconsin Physicians Service in the various categories listed on the report by Mr. Weber. In concluding the report of Wisconsin Physicians Service, Doctor Vingom expressed the feeling that there was need for a great deal of education among the physicians to clarify various misunderstandings which have arisen concerning the operation of the various insurance programs.

13. Election of Officers

Chairman of the Council.—By motion of Doctors Vingom and Wilkinson, Dr. S. E. Gavin was unanimously chosen as chairman of the Council for the ensuing year.

Treasurer.—By motion of Doctors Arveson and Christofferson, Dr. I. R. Sisk, Madison, was unanimously re-elected to serve as treasurer for the ensuing year.

Secretary.—By motion of Doctors Arveson and Ekblad, Mr. Crownhart was unanimously elected secretary of the State Medical Society for the ensuing year.

By motion of Doctors Arveson and Ekblad, the Council unanimously expressed its thanks to these three officers for their splendid work during the year just concluded.

14. Report of the Interim Committee

Doctor Stovall, as chairman of the Interim Committee, reviewed the minutes of the various meetings of the committee and signified that the initial task of the committee has been to familiarize itself with the various functions of the office personnel. By motion of Doctors Ekblad and Dessloch the report of the Interim Committee was accepted.

15. Resolution Relative to the Seal of Acceptance Granted the Two Insurance Programs

Dr. H. H. Christofferson presented the following resolution for consideration:

WHEREAS, the House of Delegates of the State Medical Society of Wisconsin, after careful study and consideration, sponsored the Wisconsin Plan of Prepaid Hospital and Surgical Insurance, and

WHEREAS, the House of Delegates more recently developed and placed into operation the service plan known as Wisconsin Physicians Service, and

WHEREAS, this Council believes both plans were developed in the best interests of the people of Wisconsin, and

WHEREAS, application was duly made to the Council on Medical Service of the American Medical Association for the seal of acceptance, and

WHEREAS, the Council on Medical Service at its interim session at Cleveland in January 1948 granted the seal of acceptance to both Wisconsin Plan and Wisconsin Physicians Service,

Be it therefore resolved, that the Council of the State Medical Society of Wisconsin record the granting of the seal of acceptance to both its plans and express its approval of the decision which will materially aid the extension of voluntary prepaid medical care plans in Wisconsin.

By motion of Doctor Christofferson and seconded by Doctor Ekblad, the resolution was unanimously adopted.

16. Resolution on Nursing Shortage

Dr. H. H. Christofferson presented the following resolution relative to the current shortage of nurses:

WHEREAS, the number of registered nurses is insufficient to properly give the nursing care required in hospitals, and

WHEREAS, the number now in training is insufficient to meet the estimated demand for the future, and

WHEREAS, some of the causes for this insufficiency are inherent in the widening fields of activity for the trained nurse, and

WHEREAS, this insufficiency is most acutely affecting requirements for bedside nursing of the acutely ill and home and institutional nursing of the chronically ill, and

WHEREAS, this insufficiency is of immediate concern to all who are responsible for the care of these patients and to the general public,

Therefore, be it resolved, that the Council of the State Medical Society authorize the appointment of a committee of five by the President of the Council to ascertain the number of nurses available now in our state for the purpose of meeting these problems, the number of nurses now in training who may in the future serve these patients and to consult with the Wisconsin Hospital Association, the Conference of the Catholic Hospital Association, the State Nurses Association and with a similar committee of the American Medical Association which is now studying this problem for the purpose of making plans to remedy the shortage of bedside nurses and those giving personal services to ill people;

And be it further resolved, that the committee be instructed to report to the House of Delegates of the State Medical Society at its next annual meeting the results of its studies with definite recommendations as to the action which the House should take regarding this matter.

Doctor Gavin suggested that the resolution be referred to the Council on Medical Service and Public Relations as this Council has a subcommittee on nursing problems. This being agreeable to Doctor Christofferson, the matter was referred to the Council on Medical Service and Public Relations for further action.

17. Copy of the Seal of the University of Wisconsin

Doctor Arveson stated that the original seal of the University of Wisconsin had recently been discovered and that if the Council desired he could secure a photographic copy of the seal to place in the new home of the State Medical Society if and when the property for a new home is acquired. By action of the Council, Doctor Arveson was directed to secure a copy of the seal for the State Medical Society of Wisconsin.

18. Acceptance of Rebates by Members of the Medical Profession

Doctor Vingom presented a resolution as follows:

WHEREAS, the House of Delegates of the American Medical Association has, as recently as June 1947, expressed its considered judgment regarding the accepting of rebates by members of the medical profession,

Be it resolved, that the Council of the State Medical Society of Wisconsin give unqualified endorsement to the resolution as offered by Dr. William Weston and as amended by motions of Dr. James Z. Appel at the June 1947 session of the American Medical Association House of Delegates.

After presentation of the resolution by Doctor Vingom there was considerable discussion, and by action of the Council the resolution was accepted with dissenting votes by Doctors Wilkinson and Arveson. By motion of Doctors Arveson and Witte the Council voted to refer the entire question to the Section on Ophthalmology of the State Medical Society and asked that the members of this Section give their considered opinion of the resolution of the American Medical Association and the stand that should be taken by the State Medical Society in reference to it.

19. Consideration of the Budget

The members of the Audit and Budget Committee spoke briefly as to the various items on the budget as submitted to the Council. By action of the Council a 10 per cent living cost bonus was voted all the staff members not covered, to be concurrent with the bonus previously extended by the Council. By motion of Doctors Fitzgerald and Dessloch the budget as submitted in the agenda was accepted in its entirety with the exception of the living cost bonus on salaries.

The 1948 Proposed Budget

The Audit and Budget Committee has two responsibilities. One is annually to audit the accounts of the Society with respect to budget action, and

the other is to review the proposed budget of the secretary and make recommendations concerning it. The budget for 1948 has been reviewed in detail by the committee, which had available to it an analysis of the various activities, and heard explanations by various staff members connected with the Society. The secretary reports that the Budget Committee by motion approved continued use of the two law firms as previously appointed by the Council in earlier years. The committee also requests that in the future where specific committee projects are detailed in the budget, the various chairmen support the budgetary needs of those projects by letter. In addition, the committee approved a mileage allowance of eight cents where cars are used in official business of the Society.

The whole purpose of the budget is to establish estimated limits as a guide to the cost of Society activities during the ensuing year. The proposed budget for 1948, explained item by item, is based upon the following estimated income for 1948. By way of explanation, it is to be noted that $1,500 from unallocated reserves of the Society is expressly set aside to adjust the unusual rent cost of 1948, and will not be a recurring item if the Society secures quarters elsewhere. On this basis, Society funds for budget purposes may be estimated as follows:

2700 full dues paying members @ $35.00	$94,500.00
Miscellaneous income from sale of Society publications, including bound copies of panels	500.00
Estimated reimbursement by Wisconsin Physicians Service and Wisconsin Veterans Medical Service Agency for cost of certain accounting procedures and other matters handled through state offices	1,500.00
Reserve allocation, excess rental costs	1,500.00
Total	$98,000.00

Special Note: The position of executive assistant, prepaid medical care insurance, is carried at full salary level ($6,600) in the proposed budget, *although this position is not now filled.* No part of this fund will be used until such time as the status of Wisconsin Physicians Service is definitely determined.

Budget Item	Total
1. *President's Travel*—This has been a standing appropriation of some years and avoids necessity of vouchering costs, etc.	$ 500.00
2. *Council and Committees* — This appropriation covers cost of the four meetings of the Council, the meetings of the Society's numerous committees, travel expenses of AMA delegates to two annual meetings of AMA, and official attendance at other meetings. If all costs were billed, double this amount would be necessary. The 1947 appropriation was $6,500. This account will carry the cost of four regional county secretary conferences	$ 6,500.00
3. *Books and Periodicals*—Supplied to officers and councilors, and various members of committees—material relating to effective discharge of official duties	250.00
4. *Auxiliary*—This is a nominal appropriation of some years' standing to aid the auxiliary in its organization activities	100.00
5. *Secretary's Salary*	9,500.00
6. *Secretary's Travel* — Attendance at AMA meetings, and various national meetings as well as most of the committee meetings held by the Society. The 1947 allowance was $1,600 but the Secretary asks the increase due to higher costs of traveling	1,900.00
7. *Assistant Secretary's Salary*	6,600.00
8. *Assistant Secretary's Travel* — In 1947, $550 was available. This is insufficient for reasons stated in No. 6	750.00
9a. *Executive Assistant — general staff.* This position was authorized in 1947 and has proven highly valuable. Duties consist in arranging meetings, handling routines in correspondence, and the like	3,600.00
9b. *General Staff Appropriation* — The 1947 appropriation was $7,900. Because of emergency increases and general higher costs, it is recommended that it be increased in 1948. This account provides for the office manager, membership clerk, and two general duty secretaries with some leeway for merit increases	8,600.00
10. *Accounting and Insurance*—The 1947 appropriation was $1,750 to include cost of all Society insurance, audits, keeping books, filing various government reports, etc. With expanded activities, this must be increased, and ultimately the Society should anticipate creating a Society position of full-time auditor, who can work with the two agencies as well as with the central office. A portion of this appropriation will be recovered from the two agencies and may total $300 or more	2,400.00
11. *Social Security and Unemployment Compensation Insurance*—This is the estimated contribution required in 1948 under the several government laws affecting the Society	400.00
12. *Rent*—General office allocation. In 1947, the total rent was $250 monthly. It is now $438.25 for the same space. This total of $5,259.00 is divided, $2,699 to this account, $1,360 to Journal, and $1,200 to account 34	2,699.00
13. *Telephone and Telegraph*—This is for general office expense. Three telephone lines are carried into the office at a fixed cost of about $720 per year. The balance is toll charges. It may be necessary to increase the line service with the present volume of calls as com-	

Budget Item	Total
plaints are frequently made as to busy signals. This total is the same as 1947	1,800.00
14. *Current Supplies and Light*—Costs of supplies are much higher than in 1946–47. It is not possible to reduce this appropriation from that in 1947	1,200.00
15. *Postage and Printing*—This account carries cost of mailing membership certificates, general correspondence, and the like. It appears to be at the minimum	2,500.00
16. *Upkeep and Fixtures*—This account is chiefly one of maintenance and repair of typewriters, addressograph, mimeograph, etc. Addressograph handles 165,000 or more mailings annually	600.00
17. *New Equipment*—This account provides for new filing cabinets, at least one new typewriter each year, and replacement of obsolete and wornout equipment. 1947 allotment was $1,100	500.00
18. *Miscellaneous*—This allocation is for unanticipated items, such as an occasional extra bulletin, perhaps part-time help, etc. 1947 appropriation: $1,700	1,200.00
19. *Group Insurance*—This covers Wisconsin Physicians Service and Blue Cross on all employees except the Secretary, who is covered under none of the existing plans	350.00
20. *Legal*—The normal legal expense has been held within an appropriation of $1,800 for some years. This covers advice to officers on legal liability and responsibility, miscellaneous inquiries of the membership constituting a matter of concern to the whole profession, miscellaneous committee activities and projects, etc.	1,800.00
21. *Bulletins to Members*—Within a similar appropriation, it used to be possible to carry four general membership bulletins each year. This same appropriation allows three	600.00
22. *Blue Book*—This has been an annual appropriation to the Journal to assist in carrying the increased costs of issuing the Blue Book edition of the Journal, which is furnished without cost to the junior and senior classes of the medical schools, and to new licentiates. The Society is called on to furnish this volume to interested physicians and societies elsewhere as well. It is significant that the Indiana State Medical Association has recently undertaken the publication of a similar issue of its Journal	750.00
23. *Hygeia*—For many years the Society has issued gift subscriptions to this publication for various state officials and others in the public health field. One industrialist recently suggested that its circulation be greatly expanded	400.00
24. *Lay Publications*—This is to cover cost of furnishing health studies and pamphlets to those passing on various public health procedures and policies, including surveys of physicians, etc.	150.00
25. *Special Bulletins* — This represents the minimum cost of periodic bulletins dealing with proposed changes in public health procedures and problems	350.00
26. *Special Reports in the Journal* — Particularly during sessions of Congress and of the state legislature—these reports concern hearings and analysis of various proposals in legislation affecting distribution and quality of medical care	150.00
27. *Telephone and Telegraph*—On matters pertaining to health legislation and the like. This represents overnormal costs of routine calls as contained in No. 13	300.00
28. *Legislative Counsel*—There are many proposals, federal and state, and a considerable number of which are considered in the interim between legislative sessions. Counsel analyze these for the Society, and assist the Secretary's office in representing views of Society in legislative halls. This appropriation is annual, and in 1946–47 the same	2,000.00
29. *Veterans Medical Care and Prepaid Medical Care Plans.* This appropriation represents a reorganization of this account as carried in the 1947 budget at a total of $2,750. With the Wisconsin Plan steadily growing, as is true with Wisconsin Physicians Service, it is readily apparent that one full-time stenographic assistant is needed under this classification. New members must be reported to WPS and Veterans Medical Service, and enrollment procedures instituted. Each year new enrollment pamphlets are needed. Note further comment under each item	
A. *Stenographic assistant*—This position already exists, but under another classification in 1947	2,040.00
B. *Wisconsin Physicians Service* — This agency covers its own administrative expense, but certain Society expense in publicizing through the Journal and in cooperative assistance is necessitated	
C. *Wisconsin Plan* — Printing and other material costs in bulletins, etc.	
D. *Experimental Program* — The Price–Taylor County experiment in the prepaid medical care of the near indigent is still being conducted. It is anticipated that detailed findings of the utmost importance will be submitted to the Society during the course of 1948	
E. *Veterans Medical Society Agency* —This is operated on a nonprofit basis by contract with the federal government. Within	

Budget Item	Total
the total appropriation studies and conferences on matters not properly administrative costs may be made. It would include participation in studies of the state program as well	1,750.00
30. *Executive Assistant* — This account carries the salary of Mr. Weber, *now on leave to and paid by* Wisconsin Physicians Service. Due to the uncertain status of that agency, the position has not been filled, and the Secretary with others in the office has reassumed this work. The function of this position is the correlation of all medical care programs and activities in health education—it is in effect an assistant secretaryship in the economic field as Mr. Ragatz serves in the field of scientific medicine. The budgeted amount will not be fully used in 1948, as it will not be drawn upon until after the status of WPS has been fully determined	6,600.00
31. *Executive Assistant, Press and Public Relations*—This position is held by Mr. Thayer, who serves as secretary to the Council on Medical Service and Public Relations. The 1947 appropriation was $3,000	3,900.00
32. *Staff Appropriation*—This appropriation provides for the salary of Mrs. Davis, in charge of the Society's radio program, and for part-time assistance. $3900 allowed in 1947	3,900.00
33. *Travel, these activities.* The 1947 allocation for Doctor Cole and employes in this classification was $1,000. This should be increased due to greater expenses of traveling	1,200.00
34. *Allocated Office Rent*	1,200.00
35. *Weekly Press Releases* — These are distributed through the Wisconsin Press Association and consist of public health information to all newspapers in Wisconsin	850.00
36. *Health Exhibits*—Prior to the war, prepared for fairs, etc. 1948 exhibit will be for Centennial, and the reserve of $500 will be utilized with the current appropriation	500.00
37. *Radio Programs*—22 stations	
a. Honorarium to Director — Doctor Cole spends three or four nights a week working up broadcasts, and about a day a week handling the correspondence from listeners. He is also available for talks before lay and professional groups	1,800.00
b. Recording and discs	1,500.00
c. Supplies, express, and postage	1,050.00
d. Printing	150.00
38. *Preparation and Distribution of Panels of Physicians Available under the Workmen's Compensation Act* —About 50,000 panels are prepared annually. Bound copies of each county panel are sold some of the participating insurance carriers. About $350 will be realized from the sale of bound copies and will be used to underwrite part of the cost of this project which is carried out each 18 months. These costs represent annual budgeting, with unused balance being forwarded each year	
a. Applications and correspondence	200.00
b. Printing and distribution	2,100.00
c. Part-time help, postage, and misc.	650.00
39. Miscellaneous items from account 30 to 39 incl. not anticipated, such as additional postage or part-time help, photograph slides, exhibit material, etc.	300.00
40. *Annual Meeting*—This appropriation is for costs in excess of income. The preprandial hour will be continued, as will the practice of paying expenses of technical exhibitors and speakers. The 1947 appropriation was $2,500, but due to an unusually high volume of commercial exhibits. it is possible to return about $1,700 of that to the revolving account. It is believed that the 1948 appropriation can be reduced	1,500.00
41. *Postgraduate Clinics*—During the fiscal year of 1947, the Society participated in twelve different clinics, but had the active and very real financial assistance of other groups. Were all costs to be borne by the Society, more than twice the amount budgeted would have been necessary. The total 1947 appropriation was $2,800	
a. Hospital Relations	400.00
b. Industrial Health	750.00
c. Cancer	200.00
d. Spring Clinics	1,200.00
42. *County Medical Research Projects*— These are encouraged by the Council on Scientific Work, which has requested moderate funds with which to provide some financial assistance, such as for a librarian or research worker. Results of these projects are to be brought to the annual meeting	500.00
43. *Wisconsin Medical Journal* — Costs in excess of advertising revenues	2,700.00

Summary by Classification

1. Personnel (Except Journal)	$45,290.00
2. Committees, Officers, and Travel	10,700.00
3. Telephone and Telegraph	2,300.00
4. Printing and Supplies	6,500.00
5. Postage and Express	4,700.00
6. Equipment and Fixtures	1,100.00
7. Specialized Assistance	7,600.00
8. Scientific	7,250.00
9. Education and Economic	3,800.00
10. Rent	3,899.00*
11. Insurance and Miscellaneous	2,250.00
Total	$95,389.00

* Total rent is $5,259.00. Balance of $1,360.00 is paid by Journal.

Conclusion

It has been customary each year to carry forward unused balances in certain of the accounts, inasmuch as they represent budget items for a period in excess of one year. For example, the industrial panels are printed twice during a three year period, and consequently the balances in this account are carried forward from year to year, with full authority for utilizing as may be approved by the Council. Under this arrangement, funds now available in accounts specified for Council and Committees, Special Bulletins and Reports in the Journal, special telephone and telegraph, medical care experiments to the extent of $650, health exhibits, panel preparation and distribution, annual meeting, and postgraduate clinics to the extent of $1,000 would be carried forward to the respective accounts in the 1948 budget. With approval of the proposed 1948 budget, approximately $3,000 would revert to unallocated reserves.

20. Report of the Special Committee on W.I.A.A. Program

Doctor Supernaw, as chairman of the special committee on the Wisconsin Interscholastic Athletic Association program, presented a detailed report of the committee's activities and asked approval of the Council of the report as submitted. After considerable discussion as to the operation of the Wisconsin Interscholastic Athletic Association program, the Council voted to resubmit the report to the Council on Medical Service and Public Relations for further study, with the suggestion that the matter might be brought to the attention of the Council at a later date.

21. Providing a Suitable Lapel Button for Members of the "Fifty Year Club"

Mr. Crownhart outlined a proposal to provide lapel buttons for members of the "Fifty Year Club," and he estimated that the total cost of such an award would not be in excess of $200. By motion of Doctor Truitt and variously seconded, the Council approved the suggestion of the secretary that a suitable lapel button be provided for members of the "Fifty Year Club" at a cost not to exceed $200.

22. Support Granted the National Society for Medical Research

Mr. Crownhart outlined the work of the National Society for Medical Research and reported that Doctor Cole had suggested that the State Medical Society might wish to support the activities of the National Society for Medical Research inasmuch as the activities of this organization have direct bearing upon advances in medical science. By motion of Doctors Arveson and Ekblad the Council voted unanimously to appropriate a sum of $100 for the support of this organization.

23. Funds to Support Scientific Programs for Councilor District Meetings

Mr. Ragatz, assistant secretary, reported that the Council on Scientific Work was suggesting to the Council the support of a program of furnishing scientific programs to councilors for councilor district meetings. It was suggested by the Council on Scientific Work that a roster of physicians from the Marquette University School of Medicine and the University of Wisconsin Medical School be provided each councilor with honorariums to be paid for either through the treasury of the State Medical Society or through the cooperating agencies, namely, the State Board of Health, the American Cancer Society, and the Bureau of Handicapped Children of the Department of Public Instruction. It was estimated by Mr. Ragatz that the maximum cost to the State Medical Society for the support of a program of this kind would not exceed $400. By motion of Doctors Bell and Arveson, a sum not to exceed $400 was appropriated for this activity.

24. Council Award

Doctor Gavin reviewed for the Council, particularly for the new members, the procedure followed in granting the Council Award for outstanding medical service. He expressed appreciation for being the recipient of the award in 1944.

25. Release of Council Affairs to the Press

The secretary asked permission of the Council to release to the newspapers the election of officers, the introduction and reference to the resolution relating to nursing education, the fact that the Council supports the position of the American Medical Association with reference to rebates and gives further support to the National Society for Medical Research. Permission was granted.

26. Reference to Condensed Activities of Various Committees

Doctor Stovall spoke to the Council briefly concerning the growing activities of committees within the State Society and urged that a study be made to see how the activities of the central office might be simplified so that the demands on the office staff, particularly the secretary, might be somewhat lessened. It was agreed that this matter would be discussed at a later date.

27. Adjournment

The meeting was adjourned at 4:05 p.m.

C. H. Crownhart
Secretary

Approved:

S. E. Gavin, M. D.
Chairman of the Council

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News Items and Personals

Dr. H. D. Ludden Retires From Practice at Mineral Point

More than two hundred guests gathered for a banquet in Mineral Point on March 15 to honor *Dr. H. D. Ludden*, who retired recently after forty years of practice in that community. The dinner was sponsored by the local American Legion post and auxiliary. *Dr. H. M. Walker*, Dodgeville, was the guest speaker for the occasion, and he traced the life and service of Doctor Ludden in Mineral Point.

Doctor Ludden, a graduate of Rush Medical School, Chicago, located in Mineral Point shortly after completing his internship at St. Mary's Hospital in Milwaukee. During World War I he served for twenty-seven months in the Army Medical Corps.

Dr. Joseph Meboe Takes Over Practice in Viola

Dr. Joseph Meboe, formerly of La Crosse, has now taken over the practice formerly held by *Dr. C. A. Morrow*, who left in March to specialize in the field of allergy. Doctor Meboe has been on the staff of the Gundersen Clinic since his release from the Army Medical Corps.

Medical Staff Organized For Oconto County and City Hospital

At a dinner meeting on March 13, a medical staff for Oconto County and City Hospital was organized to improve the service to patients by providing a system for reviewing past cases and arranging consultation. Among the speakers were Dr. L. G. Glickman, roentgenologist, and *Dr. R. J. Rogers*, pathologist. Two movies on surgery were also shown.

Dr. L. S. Shemanski Joins Wild Rose Hospital Staff

Dr. Leonard S. Shemanski, formerly of Menasha, recently joined the staff of the Wild Rose Hospital as surgeon. During the war the doctor served for four years with the Army Medical Corps in the Pacific.

Neuropsychiatrist Opens Neenah Office

Dr. E. Madison Paine recently opened an office in Neenah for the practice of neuropsychiatry. Formerly associated with the staff of Milwaukee Sanitarium at Wauwatosa, the doctor served during World War II as chief of the neuropsychiatric service of the Twelfth Station Hospital in Australia and later was attached to hospitals in New Guinea and Manila.

Dr. M. J. Murphy Moves to West Virginia

Formerly school physician in Wauwatosa, *Dr. Maurice J. Murphy* recently resigned that position to begin practice in Welch, West Virginia. There he will be associated with the staff of the Stevens Clinic Hospital.

Racine Doctor Addresses Nurses Group

Dr. William H. Bennett, Racine, spoke before a meeting of the Kenosha Hospital Alumni on March 24 at the Nurses' Home His subject was "Orthoptics and Orthoptics Training."

Dr. T. N. Robinson Opens Oconto Falls Practice

Dr. T. N. Robinson recently announced the opening of a general medical practice in Oconto Falls. The doctor, formerly located in Wittenberg, will occupy the office of the late *Dr. H. F. Ohswaldt.*

Dr. R. C. Brown Speaks to Staff of Theda Clark Memorial Hospital

Dr. R. C. Brown, Neenah, reported on the meeting of the American Academy of Orthopedic Surgeons at a meeting of the staff of Theda Clark Memorial Hospital on March 20. Doctor Brown confines his practice in Neenah to orthopedic surgery.

DR. W. J. POTTS TO SPEAK AT OUTAGAMIE COUNTY MEDICAL SOCIETY MEETING

Members of neighboring county medical societies are invited to attend the May meeting of the Outagamie County Medical Society, when the guest speaker will be Dr. Willis J. Potts, professor of pediatric surgery at Northwestern University Medical school and also chief of the surgical staff at the Chicago Children's Hospital. Doctor Potts will discuss "The Diagnosis and Surgical Treatment of Congenital Heart Lesions." The meeting will be held at the Conway Hotel, Appleton, at 6:30 p.m. on May 21.

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SOCIETY PROCEEDINGS

Eau Claire—Dunn—Pepin

"Recent Advances in Therapy" was discussed by *Dr. Ovid O. Meyer*, Madison, at the April meeting of the Eau Claire–Dunn–Pepin County Medical Society held at the Elks Club in Eau Claire on April 26. Doctor Meyer is professor of medicine at the University of Wisconsin Medical School.

Dr. Malcolm Dockerty of Mayo Clinic, Rochester, Minnesota, spoke at the meeting of the Eau Claire-Dunn–Pepin County Medical Society on March 29 at the Elks Club in Eau Claire. His paper, entitled "Ovarian Tumors," consisted of a discussion of the gross and microscopic pathology of ovarian tumors together with a lantern slide demonstration.

Dr. F. R. Town, who assumed his duties as Eau Claire city and county health officer on March 17, was introduced to the Society, and the public relations committee was authorized to work with him as a public health committee.

Green Lake—Waushara

Meeting at the Chase Hotel in Wautoma on May 18, members of the Green Lake–Waushara County Medical Society heard a talk by *Dr. Sture A. M. Johnson*, Madison. Doctor Johnson, who is professor of dermatology and syphilology at the University of Wisconsin Medical School, discussed "The Diagnosis and Treatment of Common Dermatological Conditions."

Manitowoc

The Wisconsin Physicians Service plan was outlined for members of the Manitowoc County Medical Society by Mr. J. Jackson, Stevens Point, at a meeting at Hotel Manitowoc on March 25. Mr. Jackson is the claims manager of the Hardware Mutual Casualty Company. An open discussion followed, with participation by members of the Society and representatives of the insurance company, Mr. M. LeBreck and Mr. J. Kornelly, district adjusters, and Mr. Drew, manager of the branch office at Appleton.

Pierce—St. Croix

Dr. R. N. Bieter, head of the department of pharmacology at the University of Minnesota Medical School, was the guest speaker at a meeting of the Pierce–St. Croix County Medical Society at Hotel Hudson in Hudson on April 19. His subject was "Chemotherapy."

Rock

A dinner meeting of the Rock County Medical Society was held at the Monterey Hotel in Janesville on April. 27. The guest speaker for the evening was *Dr. A. C. Schmidt*, orthopedist at the Milwaukee Children's Hospital, who spoke on "Management of Fracture in Children."

Richland

G. E. OOSTERHOUS

"Diagnosis and Treatment of Diarrhea in Infants" was the title of a paper presented at the meeting of the Richland County Medical Society at the Richland Hospital in Richland Center on April 6 by *Dr. George Oosterhous* of Madison. Doctor Oosterhous is a specialist in pediatrics.

Sheboygan

Members of the Sheboygan County Medical Society gathered at the Memorial Hospital in Sheboygan on March 30. Mr. Richard Froehlich, administrator of the Sheboygan County Welfare Department, talked to the group on "Policies and Procedures of the Sheboygan City Welfare Department." *Dr. C. J. Weber* presented a paper on "Papanicolaou Technique in Cancer Diagnosis," with illustrations, and *Dr. Paul B. Mason* conducted an open discussion to clarify and differentiate the Wisconsin Plan and Wisconsin Physicians Service.

Trempealeau—Jackson—Buffalo

Dr. James C. Fox, La Crosse, councilor for the Seventh Councilor District, reported on the last Council meeting of the State Medical Society, when members of the Trempealeau–Jackson–Buffalo County Medical Society met at the Arcadia Hotel in Arcadia on April 15. A case report was also presented and an open discussion followed.

Sauk

The Sauk County Medical Society held its monthly meeting on April 15 in the Silver Room of the Warren Hotel at Baraboo. Guest speaker was *Dr. Lewellyn R. Cole*, Madison, who is coordinator of graduate medical education at the University of Wisconsin Medical School.

Winnebago

Dr. H. H. Shapiro, Madison, was the guest speaker at the meeting of the Winnebago County Medical Society held at the Athearn Hotel in Oshkosh on April 1. Doctor Shapiro, who is assistant professor of medicine at the University of Wisconsin Medical School, entitled his talk "Recent Advances in the Treatment of Decompensation."

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Wisconsin Urological Society

Members of the Wisconsin Urological Society met for a full day's session at the Gundersen Clinic in La Crosse on April 24. The morning and afternoon were devoted to scientific programs, and a luncheon was held at the La Crosse Club at noon. Drs. N. G. Alcock, Iowa City, Iowa, and Walter Zeit, Milwaukee, were the guest speakers, presenting discussions of "Tumors of the Adult Kidney" and "Anatomy of the Male Perineum" respectively. Doctor Alcock is professor of urology at the State University of Iowa College of Medicine, and Doctor Zeit is professor of anatomy at Marquette University School of Medicine.

At the business meeting the following officers were elected: president, *Dr. N. W. Bourne*, Milwaukee; vice-president, *Dr. Charles R. Marquardt*, Milwaukee; and secretary–treasurer, *Dr. Dwight Spooner*, Milwaukee.

The program was as follows:

Pyelogram Clinic
Moderators:
Dr. Ira R. Sisk, Madison
Dr. Walter M. Kearns, Milwaukee

"Hypernephroma with Intracaval Extension"
Dr. Theodore Beutler, Wood

"Renal Agenesis"
Dr. Ray C. Johnston, Wood

"Traumatic Renal Cyst"
Dr. Donald W. Calvy, Wood
Discussant: *Dr. James C. Sargent*, Milwaukee

Movie on Wilms' Tumor
Dr. Leland C. Pomainville, Wisconsin Rapids
Discussant: *Dr. N. W. Bourne*, Milwaukee

"Torsion of the Testicle"
Dr. Sidney J. Silbar, Milwaukee
Discussant: *Dr. Robert S. Irwin*, Milwaukee

"Recent Advances in Intravenous Urography"
Drs. George H. Ewell and *Harold W. Bruskewitz*, Madison
Discussant: *Dr. Alexander Schlapik*, Kenosha

Luncheon

"Osteitis Pubis Following Ureterolithotomy in a Female"
Dr. E. J. McGinn, Marshfield

"Anatomy of the Male Perineum"
Dr. Walter Zeit, Milwaukee

"Radical Perineal Prostatectomy"
Dr. John B. Wear, Madison
Discussant: *Dr. Dwight Spooner*, Milwaukee

"Tumors of the Adult Kidney"
Dr. N. G. Alcock, Iowa City, Iowa
Discussant: *Dr. Ira R. Sisk*, Madison

"Carcinoma of the Bladder, Ureterosigmoid Transplant"
Dr. Sidney P. Hurwitz, Milwaukee
Discussant: *Dr. James C. Sargent*, Milwaukee

"Statistical Analysis of One Hundred Consecutive Transurethral Resections of the Prostate Gland"
Dr. Maxwell Johnson, La Crosse
Discussant: *Dr. Cyril G. Richards*, Kenosha

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—Editor's Note

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

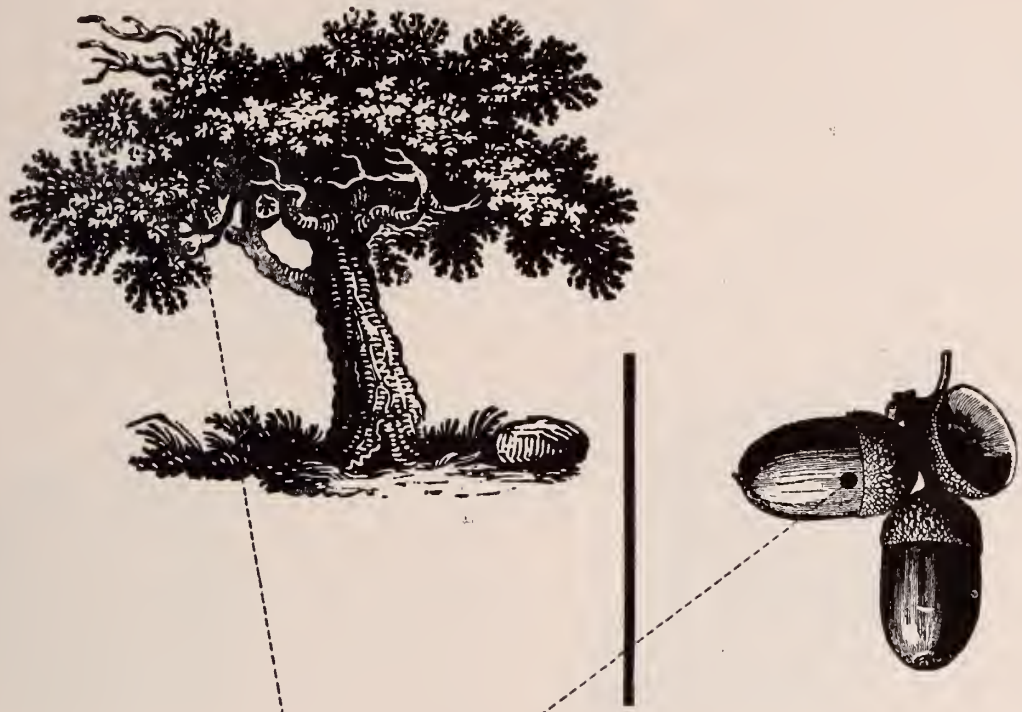
Members of the Columbia–Marquette–Adams County Medical Society met at St. Savior's Hospital in Portage on April 13. *Dr. H. A. Winkler*, Pardeeville, read a brief paper on the cancer symposium which he attended during March at the State of Wisconsin General Hospital, and members were enthusiastic in their willingness to cooperate with the program.

Dane

Medical insurance was discussed at a meeting of the Dane County Medical Society held at the Madison Club on April 13. The prepaid medical care plans approved by the State Medical Society and the methods by which doctors obtain authority to treat veterans with service-connected disabilities were described. Speakers included Mr. C. H. Crownhart, secretary of the State Medical Society; Mr. L. K. Wheeler, executive secretary of Associated Hospital Care Plans, Inc.; Mr. Ralph Weber, director of Wisconsin Physicians Service; and Mr. Thomas J. Doran, director of the Wisconsin Veterans Medical Service Agency.

University of Wisconsin

Dr. Robert F. Pitts, professor of physiology and departmental chairman in physiology at the Syracuse University School of Medicine, spoke before the meeting of the University of Wisconsin Medical Society in the Service Memorial Institutes Building on April 29. The doctor, whose subject was "Renal Factors in the Regulation of the Acid-Base Balance," has contributed a large number of papers to the scientific literature in physiology.



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THIRD DISTRICT NEWS

Dr. H. E. Gillette Named Chairman of Welfare Committee

Dr. H. E. Gillette, Pardeeville, was elected chairman of the Columbia County Child Welfare Advisory Committee at a meeting on March 24. The doctor has retired from active medical practice.

Drs. J. F. and R. F. Poser Open Office in Madison

Two Columbus doctor-brothers, *Drs. John F.* and *Rolf F. Poser*, opened an office in the Tenney Building, Madison, on March 22, where they will see patients by appointment. They will also continue their practice in Columbus, where they have been associated for several years with their father, *Dr. E. M. Poser*. Dr. John Poser specializes in surgery, and Dr. Rolf Poser is a specialist in internal medicine. Both are graduates of the University of Wisconsin Medical School.

T. W. Dasler Joins Clinic Staff at Wisconsin Dells

Dr. T. W. Dasler, formerly of Madison, recently joined the staff of the Wisconsin Dells Clinic. Doctor Dasler served with the Army Medical Corps before locating in Madison.

Dr. Marion Hines Delivers Helmholz Lectures

Dr. Marion Hines, professor of anatomy at Emory University School of Medicine, Atlanta, Georgia, delivered a series of lectures at the Service Memorial Institutes Building, April 26–28, on the A. C. Helmholz lectureship, which was endowed in 1941 by the children of Mr. and Mrs. A. C. Helmholz of Milwaukee. Doctor Hines has carried on a large number of experiments with infant monkeys and has made some significant observations on the biosocial development which are of great interest to workers in the field of physical and emotional development. The subjects of her lectures were "The Cortical Control of Movement," "Extrapyramidal and Pyramidal Activity," and "The Development of the Infant Macaque."

SOCIETY PROCEEDINGS

Milwaukee Oto-Ophthalmic Society

Dr. Beulah Christman of Northwestern University Medical School was the guest speaker of the meeting of the Milwaukee Oto-Ophthalmic Society held April 27 at the Milwaukee Children's Hospital. She presented a paper on "Surgery of Strabismus with Special Reference to the Oblique Muscles." *Dr. Howard High* of Milwaukee spoke on the "Treatment of Acute Laryngotracheobronchitis."

Milwaukee Neuro-Psychiatric Society

The Winnebago State Hospital at Winnebago was the meeting place for the Milwaukee Neuro-Psychiatric Society on April 22. Following a dinner at the hospital, the staff of the institution presented the scientific program. *Dr. J. T. Petersik* spoke on "The Incidence of Huntington's Chorea in Admissions at the Winnebago State Hospital"; *Dr. L. B. Perssion* discussed "Contrasting Series of Convulsive Shock Therapy"; Dr. J. J. Mulvaney presented a "Tuberculosis Control Program in a Hospital for the Mentally Ill"; and *Dr. Byron J. Hughes* presented a paper on "Conditioned Reflex Therapy in 250 Cases."

TWELFTH DISTRICT NEWS

G. E. Collentine Presented Marquette University Alumni Award

Dr. George E. Collentine, Jr., Milwaukee, was awarded the annual Marquette University Medical alumni scroll at the spring clinic at the Marquette University School of Medicine on May 13. Doctor Collentine, a 1943 graduate, was presented the award because of his work on thrombosis. Following a period in the Navy, he was a research fellow in the department of biochemistry at Marquette. At present he is taking postgraduate work in general surgery at the University of Pennsylvania School of Medicine.

SOCIETY RECORDS

New Members

Albert J. Bown, Veterans Administration, Waukesha.

Adolph M. Whiting, 522 Second Street, West, Ashland.

John J. Mueller, 518 Exchange Building, La Crosse.

Landon M. Lapham, Balsam Lake.

Adrian W. Davis, 3336 Monona Drive, Madison.

Raymond M. Baldwin, Medical Director, Fisher Division General Motors, Janesville.

Stanley J. Graiewski, Rittenhouse Avenue, Bayfield.

George H. Handy, 214 West Grand Avenue, Wisconsin Rapids.

Thomas J. Bens, Lafayette Home Hospital, Lafayette, Indiana.

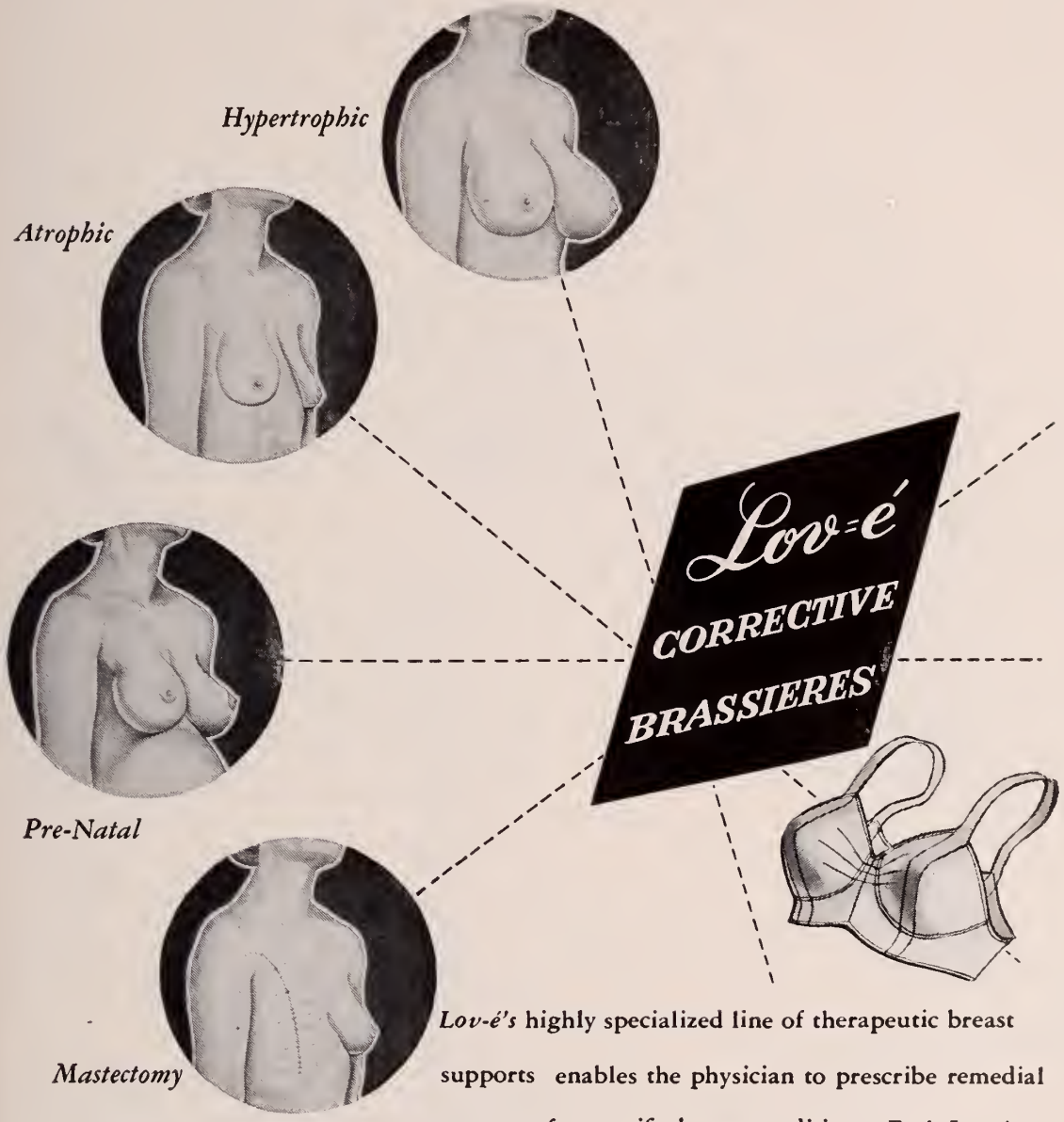
George H. Smullen, 322 Main Street, Racine.

Harry E. Schaefer, 1015A Washington Street, Manitowoc.

Frank J. Gouze, Marshfield Clinic, Marshfield.

Harold G. Pudleiner, 513 Fourth Street, Algoma.

Richard L. Johnson, Milwaukee County General Hospital, Milwaukee.



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Eugene J. Hohler, Mineral Point.

George J. Twohig, Kiel.

Robert E. Lund, Cumberland.

Gerard I. Uhrich, 508 Batavian Bank Building, La Crosse.

Changes in Address

E. E. McCandless, Birnamwood, to Wittenberg.

Joseph Meboe, La Crosse, to Viola.

L. S. Shemanski, Menasha, to Wild Rose.

J. F. Poser, Edgerton, to Columbus.

H. M. Snodgrass, Janesville, to Veterans Administration, Wood.

Frederick Rosenfeld, Phelps, to Philip, South Dakota.

J. D. Walsh, Wauwatosa, to 505 Oak Park Avenue, Oak Park, Illinois.

H. R. Alpert, Torrance, California, to 809 North Avalon Boulevard, Wilmington, California.

F. E. Gehin, Madison, to 401 Main Street, Stevens Point.

F. C. Williams, Jr., South Milwaukee, to 7507 Sheridan Road, Kenosha.

E. Madison Paine, Wauwatosa, to 104 North Commercial Avenue, Neenah.

R. T. Hansen, Wauwatosa, to RFD Hartland.

J. W. Nellen, Philadelphia, Pennsylvania, to Bellin Building, Green Bay.

E. T. Rechlitz, Spring Grove, Minnesota, to 517 Triangle Drive, Albert Lea, Minnesota.

MARRIAGES

Dr. Wellwood M. Nesbit and Mrs. Maria Kant, Madison, on March 25.

Mary Patricia Heydon and Dr. A. T. Leininger, both of Green Lake, on April 3.

DEATHS

Dr. Herbert J. Orchard, 79, prominent Superior physician, died at his home in that city on March 25. Recently made a life member of the State Medical Society, he had observed his fiftieth anniversary of medical practice in 1945.

Doctor Orchard was born on October 5, 1868, in Shedden, Ontario, Canada. Following graduation from the Medical Faculty of Trinity University at Toronto in 1892, he established his practice in Superior, which he continued until the time of his death.

In 1906 the doctor served as city health officer, and for many years he was in charge of the Free Chest Clinic maintained by the city. He served as chief of staff of St. Mary's Hospital in 1922 and again in 1938, and in 1937–1938 was delegate from the Douglas County Medical Society. For many years he was in charge of the weekly tuberculosis clinic held at the city health department. At the 1947 annual meeting of the State Medical Society he was named to membership in the Fifty Year Club.

In addition to his life membership in the State Medical Society, Doctor Orchard was also a member of the Interurban Medical Association, the Douglas County Medical Society, and the American Medical Association.

He is survived by one daughter.

Dr. A. J. Somers, 74, physician at Chippewa Falls for twenty-seven years, died at a hospital in that city on March 25. The doctor, who had specialized in treatment of the eye, ear, nose, and throat, had retired from practice three years ago.

Born in Milwaukee on August 4, 1873, he received his medical education at Milwaukee Medical College, now Marquette University School of Medicine, graduating in 1905. He remained there to teach gynecology for several years, and then moved to Portal, North Dakota, where he conducted his own hospital. After specializing in treatment of the eye, ear, nose and throat in Chicago, he located in Chippewa Falls, where he practiced until his retirement in 1945.

Doctor Somers was a member of the Chippewa County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and a son.

Dr. F. L. Phillips, ophthalmologist at Chippewa Falls for thirty years, died at a hospital in that city on April 13. He was 65 years old.

Born in Chippewa Falls on August 31, 1882, the doctor became a civil engineer before entering medical school. He graduated from the Wisconsin College of Physicians and Surgeons, now Marquette University School of Medicine, in 1911, following which he entered general practice in Rice Lake. Several years later he took postgraduate work in treatment of the eye, ear, nose, and throat at Rush

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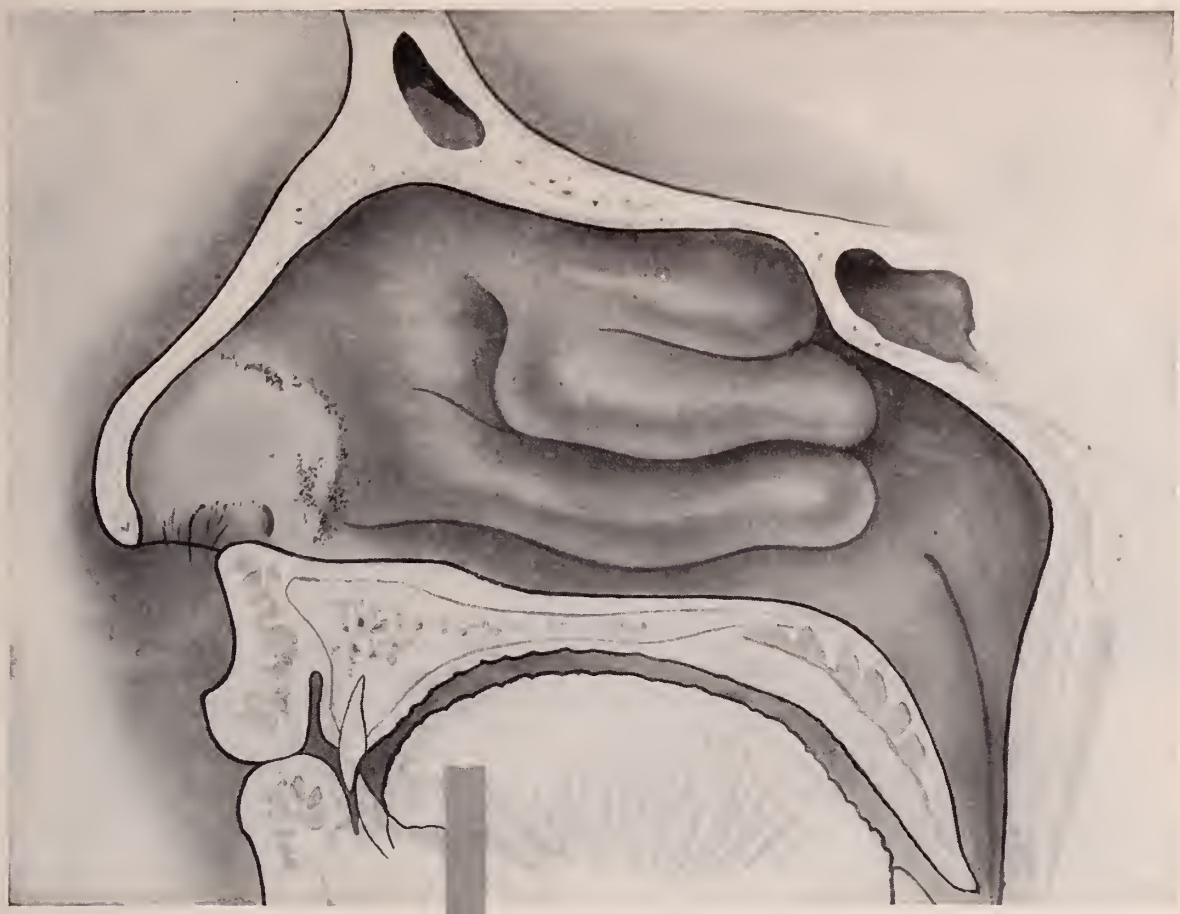

ciliary

activity in

COLDS
SINUSITIS
HAY FEVER

Ciliary motion carries away exudative debris in the upper respiratory passages. This action should not be inhibited by therapy of the common cold, sinusitis or hay fever.

The isotonic solutions of Neo-Synephrine hydrochloride permit ciliary function to continue in an efficient manner, while congestion is reduced by vasoconstriction.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

NEO-SYNEPHRINE®
HYDROCHLORIDE
BRAND OF PHENYLEPHRINE HYDROCHLORIDE

Supplied in ¼% solution (plain and aromatic), 1 oz. bottles. Also, 1% solution (when greater concentration is required), 1 oz. bottles, and ½% water soluble jelly, ⅝ oz.

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Neo-Synephrine, trademark reg. U.S & Canada.

Prescribe Journal-advertised products and you prescribe the best.

Medical College, interning at Presbyterian Hospital in Chicago. In 1917 he opened the practice in Rice Lake. He moved to Chippewa Falls in 1919, where he continued practice until his death.

He was a member of the Phi Rho Sigma medical fraternity and a member of the Volunteer Medical Service Corps in World War I.

He is survived by his wife and a son.

G. V. I. BROWN

Dr. George Van Ingen Brown, 86, internationally known oral and plastic surgeon, died at a Milwaukee hospital on April 2. The doctor, who had practiced in Milwaukee since 1898, had retired from operative practice in 1942.

Doctor Brown was noted especially for his work following World Wars I and II in rebuilding the faces and jaws of wounded soldiers. He had volunteered his services at the beginning of the last war and was on the consultant service exchange in the federal building. During World War I he was a major in the Army Medical Corps, serving as head of the subsection on oral and plastic surgery of the head surgery division at the office of the surgeon general and later as chief of the maxillofacial service at Walter Reed Hospital, Takoma Park, Washington, D. C. In 1918, under orders from the surgeon general, he organized a school of plastic surgery at Fort Oglethorpe, Georgia. The following year he was appointed surgeon of the United States Public Health Service with the Bureau of War Risk Insurance as consultant in plastic surgery at Milwaukee.

His life interest was centered in the development of better methods of operation for hare lip and cleft palate. He contributed extensively to the literature on the subject, and in 1911 was appointed to make a report on it before the International Medical Congress in Budapest. When the American College of Surgeons met in London in 1914, he was in charge of the program and contributed to it on the subject of hare lip and cleft palate. The United States Senate named him the delegate to the International Medical Congress in Madrid in 1903, and that same year he represented the Organization Committee of the International Exposition at St. Louis at the meeting of the International Dental Federation at Madrid to secure action for the International Dental Congress at St. Louis, to be held in connection with that exposition.

Born in St. Paul, Minnesota on January 15, 1862, he received a D.D.S. degree from the Pennsylvania College of Dental Surgery, Philadelphia in 1881 and his medical degree from Marquette University School of Medicine in 1909. In addition to carrying on a private practice over a period of years, he also lectured at various universities, and from 1920 to 1937 he was professor of oral and plastic surgery at the University of Wisconsin Medical School. Chief of staff of St. Mary's Hospital, Milwaukee, in 1936, he also served on the staffs of Columbia and Milwaukee County Hospitals in Milwaukee and of the State of Wisconsin General Hospital and Wisconsin Orthopedic Hospital for Children in Madison.

The doctor was a member of many national and international medical societies, a number of which conferred upon him special honors. The Italian Physico-Chemical Academy awarded him the medal of honor for scientific work, and a New York society presented him with the Jarvie Gold Medal for oral surgery in 1921. A fellow of the American College of Surgeons, he was also an honorary member of La Societe Belge de Stomatologie, the American Society of Plastic and Reconstructive Surgery, the Milwaukee Academy of Medicine, and the International College of Surgeons. He was a member of the Founders' Group of the American Board of Plastic Surgery, the Medical Society of Milwaukee County, and the American Medical Association, and in 1945 he was made a life member of the State Medical Society.

He is survived by a son, Dr. Selby V. I. Brown.

Dr. Stilwell G. Meany, physician at East Troy for many years, died at his home in that community on April 4. He was 57 years old.

Doctor Meany was born in Kaukauna on February 23, 1891. He received his medical education at Marquette University School of Medicine, graduating in 1913. Following internship at Trinity Hospital in Milwaukee, he established his practice in East Troy, where he practiced until his death. The doctor was chief of staff of the Walworth County Hospital at Elkhorn, and for many years served as health officer for East Troy township and village.

The doctor was a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife and a daughter.

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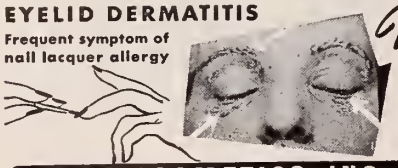
Frequent symptom of nail lacquer allergy



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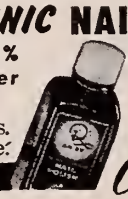
In clinical tests proved SAFE for 98% of women who could wear no other polish used.
At last, a nail polish for your allergic patients. In 7 lustrous shades. Send for clinical resume.



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For surface infections...

New and Nonofficial Remedies · 1947 · states: "NITROFURAZONE.—Furacin... possessing bacteriostatic and bactericidal properties . . . effective in vitro and in vivo against a variety of gram negative and gram positive bacteria . . . is useful for topical application in the prophylaxis and treatment of superficial mixed infections common to contaminated wounds, burns, ulceration and certain diseases of the skin . . . Variant bacterial strains showing induced resistance to sulfathiazole, penicillin or streptomycin are as susceptible to nitrofurazone as their parent strains . . ." Furacin N.N.R. is available in the form of Furacin Soluble Dressing containing 0.2 per cent Furacin. This preparation is indicated for topical application *in the prophylaxis and treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.* EATON LABORATORIES, INC., NORWICH, N. Y., — TORONTO, CANADA

CORRESPONDENCE

MINNESOTA MEDICINE
Published Monthly by the Minnesota State Medical Association

April 15, 1948

Dear Sir: Just a few lines to thank you for inviting us to use the advertising copy in *Minnesota Medicine* that you scheduled for the Wisconsin Journal. Your kindness and cooperation is appreciated. We shall accept your invitation gratefully although we may make some minor changes in the wording of the copy.

This is a splendid idea and I have often thought of suggesting something of the kind but have never done so. Unfortunately, we never hear much from the doctors as to whether they read the advertisements in their own journals but I dare say if we should make some ultraradical and untrue statements in the ads we would quickly learn that most of them do.

Cordially,
(Signed) J. R. BRUCE
Business Manager
Minnesota Medicine

March 31, 1948

Paul A. Brehm, M. D.
Wisconsin State Board of Health
Industrial Hygiene Unit
Madison 2, Wisconsin

Dear Dr. Brehm: The Industrial Health Bulletin is really tops. If you have them, I would surely like to have about sixty copies to send out to leaders in industrial medicine of the East and West Coast as well as around here. It is very attractively and vividly put together and should really be a workbook for industry and its staff of people taking care of the health and safety of employees.

I should also like to know if I may take some copies or send some copies to my friends in England who would be deeply grateful for this opportunity to get the overall picture.

Cordially,
(Signed) HEDWIG S. KUHN, M. D.
Secretary, Joint Committee on Industrial Ophthalmology

WISCONSIN PHARMACISTS

The pharmacies listed in this section have been recommended as rendering the type of prescription service in keeping with high medical standards.

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CENTRAL DRUG
An unusually large stock of
Pharmaceuticals and Biologicals
Adams 240
Green Bay, Wisconsin

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Prescription Specialists
Two Stores
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MATHER PHARMACY, INC.
K. M. Nelson E. H. Geske
Prescription Experts
Telephone Dial 3211
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★ KENOSHA COUNTY ★

MAYER DRUG
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A Complete Prescription Department
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★ OUTAGAMIE COUNTY ★

Safe Prescription Service Since 1910
SCHLINTZ BROS. DRUG STORE
College Avenue at State
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Registered Pharmacist in charge at all times.

When writing advertisers please mention the Journal.

Pharmaceutical News for Physicians

Every three months the Wisconsin Pharmaceutical Association will present two pages in The Wisconsin Medical Journal of Pharmaceutical news which will be of interest to Wisconsin physicians.

THE WAY OF NEW DRUGS — A review of the development of therapeutic agents indicates that many of them have passed through periods of severe criticism before proper evaluation of their therapeutic usefulness has been made. Soon after the new drug becomes available, many favorable reports appear concerning its efficacy in a variety of clinical conditions. Over-enthusiasm is followed by disappointments, enthusiasm wanes and warnings are issued that the new drug is a toxic substance. Thereafter, the new drug gradually reaches its correct place among therapeutic agents with the realization that every therapeutic agents has its limitations as well as indications. Diethylstilbestrol, Thiouracil, Propyl Thiouracil, Penicillin, Streptomycin, the sulfonamides and vitamins, particularly those of the B complex, have had this history.

AMA SETS UP RULES ON "AMINO" PRODUCTS — Only those amino acid and protein hydrolysate preparations that provide adequate quantities of each of the essential amino acids are now considered acceptable for inclusion in the 1948 edition of New and Non-official Remedies by the Council on Pharmacy and Chemistry of the American Medical Association, according to a statement by Dr. Austin Smith, secretary of the Council.

The essential amino acids are: phenylalaine, tryophane methionine, lysine, leucine, isoleucine, threonine, valine, histidine, and arginine.

The Council requires that all hydrolysates be labeled with: (1) The appropriate generic designation, which should include dextrose or other suitable carbohydrate when this is added.

(2) The identity of the protein or source of protein from which the hydrolysate is derived when this is not declared in the descriptive designation.

(3) The method of hydrolysis (acide, enzymatic, or other).

(4) The nature of modification in amino acid content after hydrolysis, if any.

(5) The percentage of each amino acid or its equivalent that is present.

(6) The precentage of alpha nitrogen that is represented in relation to the total nitrogen content of the mixture.

The Council has deferred acceptance of preparations containing added vitamins or other substances considered essential for adequate nutrition pending adequate justification for such preparations.

Mixtures of pure synthetic amino acids to be used for nutritional states or preparations of the individual pure amino acids for specific purposes will be considered by the Council as the evidence for their usefulness is established.

At present, the Council considers preparations of intact proteins used orally as food supplements outside its scope, unless specific therapeutic value is established for such products.

'49 NNR EDITION DROPS THIOURACIL & SULFATHIAZOLE — Sulfathiazole and thiouracil will be omitted from the 1949 edition of NEW AND NONOFFICIAL REMEDIES, the Council on Pharmacy and Chemistry of the American Medical Association decided at a recent meeting.

This decision conforms with the Council's policy of withdrawing acceptance of a toxic drug when a less toxic but equally effective agent becomes available, Dr. Austin Smith, secretary of the Council, declares.

The omission of sulfathiazole has been made because less toxic sulfonamide compounds, penicillin, and streptomycin may be used instead, the Council believes.

Thiouracil has been withdrawn because the Council is of the opinion that propylthiouracil provides all the benefits that could be expected from thiouracil with a mere fraction of the unfavorable actions.

"WARTS" — The lowly wart is one of the skin diseases most frequently observed in general practice. It is especially common among young patients.

Although there is a correct, though vague, idea among laymen that warts are contagious, it is not generally known that they are caused by a specific infection, viral in nature.

If warts are curetted off, ground up in saline solution, and this solution is passed through a Berkfeld filter, the filtrate will produce warts at the site of inoculation into the skin of human volunteers or experimental animals. The incubation period is quite variable, but nearly always quite long. As long a period as eighteen months may elapse between inoculation and the appearance of the wart. Others have stated that this interval may be as long as several years. This fact has great bearing upon the cure of a crop of warts in an individual. For after the physician has thoroughly and successfully destroyed every trace of visible warts he cannot assure the patient that others have not already been "planted" and may not develop several months later. This point should be carefully explained to the patient.

Ease of curability of warts varies from the facility with which Tom Sawyer cured his with stump water to the difficult cases in which removal of areas of skin followed by grafting is necessary.

In following any method of treatment of warts, one should remember that they are benign growths, that they are rarely harmful and that they may spontaneously disappear. Therefore, any treatment which might do the patient harm should be avoided. (California Medicine)

VITAMIN A SYNTHESIZED — Several grams of a light yellow, viscous oil occasioned more than ordinary interest at the recent meeting of the American Chemical Society. Here, for the first time, was pure vitamin A—not from the livers of fish, but from the test tubes of the scientist. Synthesis had been completed which had the same potency of the natural product but without a fish odor.

Commercial production can be expected soon, following the successful synthesis of this important vitamin.

DO YOU RECALL? — The *Pharacopoeia* contains three official gels: Aluminum Hydroxide Gel, Dried Aluminum Hydroxide Gel, and Aluminum Phospate Gel.

The U.S.P. average daily dose of *Injection of Liver* is one unit. The unit is the quantity per day which may be expected to be beneficial in pernicious anemia.

VITAMIN E IN VASCULAR DISEASE —For many years, the vitamins have been considered to be mere food accessories that could be taken or left alone. However, recent work opens a new concept in the treatment of vascular disorders. These studies show irrefutable evidence that

patients suffering with coronary disease, hypertension, thrombophlebitis, thromboangiitis obliterans, indolent varicose ulcers, Raynaud's disease and cerebral thrombosis derive benefit from the administration of from 300 to 1100 mg. of a tocopherol in therapeutic dosage for a period of nine to forty days.

It has also been advocated that these patients who show clinical improvement be maintained on 100 to 150 mg. for an indefinite period of time. The authors postulate the theory that perhaps this substance may soon rank as a true chemotherapeutic agent to be administered in doses comparable to those of the sulfonamides and penicillin and even perhaps as a preventive of thrombophlebitis in herniotomies and pelvic operations.

Although the series of reported cases is small, it appears that the tocopherols may achieve results comparable to surgical interruption of the sympathetic chain by either replenishing a rapid wasting of tocopherals or combating of the continued production of some noxious bodily antagonist.

At least it is possible that there may be a medical method of treating a medical condition without the necessity of resorting to radical surgical procedures on the sympathetic nervous system which have, of necessity, been empirical and radically destructive. (Journal of Iowa State Medical Society.)

BARIUM SULFATE — In prescriping *barium sulfate* the physician should write the complete name of the substance to avoid confusion with the highly poisonous barium sulfide or the sulfite. The pharmacist must exercise extreme care to avoid dispensing the latter substance when the insoluble and harmless sulfate is prescribed.

MIXED SULFONAMIDE THERAPY – The increasing popularity of so-called "mixed sulfonamide therapy" arises from a more widespread recognition of certain facts established by careful experimental and clinical investigations, and in no sense represents an example of "shotgun" therapeutics or poly-pharmacy. The basic principle

is not so much therapeutic as it is physicochemical, deriving simply from the fact that a sulfonamide is practically as soluble in a solution of another sulfonamide as it is in the solvent alone. The practical value of this observation is that an effective dosage level may be obtained with the concurrent administration of two or more sulfonamides without danger of intrarenal precipitation (crystalluria), whereas the same dosage of a single drug would lead to a urine concentration sufficient to cause precipitation. In mixed sulfonamide therapy the danger of intrarenal precipitation exists only to the same extent as if any one of the drugs were being administered alone in the same dosage as it occurs in the mixture.

It should be recognized, however, that this therapy does not preclude the usefulness of alkalization and the necessity of maintaining an adequate fluid intake.

TEROPTERIN IS NOW AVAILABLE — Teropterin Sodium Pteroyl Triglutamate is indicated for the palliation of malignancy. The palliative action of this compound in greatly improving the well-being of patients suffering from certain types of malignancy, and its ability to lessen pain in many instances, makes it well worth employing solely as a palliative. All forms of treatment—radium, X-ray, Surgery—for the primary malignancy and its metastases should always be employed.

The following dosage plan has been found appropriate by a number of clinical investigators; Inject 10 mg. (1cc) once daily for the first week. Beginning with the second week, two 10 mg. injections may be given daily for a period of three or four weeks. At the end of this time, it may be desirable to stop therapy to evaluate the situation and decide whether or not it is advisable to continue further medication.

Teropterin Sodium Pteroyl Triglutamate is believed to possess no toxicity in the doses recommended. This substance is not a substitute for any of the recognized methods of arresting malignant growth, and all such methods should be employed simultaneously with its administration.

ANTI-HISTAMINE DRUGS — Dr. S. M. Feinberg, of Chicago, has reported the results of investigations on a series of well-known drugs that act against histamine, the

body tissue chemical considered involved in many allergic reactions. He found that such drugs as Benadryl (Parke Davis), Pyribenzamine (Ciba), Neoantergan (Merck), Antistine (Ciba) and Theylene (Abbott) all have antihistamine effects, and may be useful in the control of certain allergic symptoms—allergic rhinitis, urticaria, edema, serum sickness, itching, dermatitis, and so forth.

The drugs prevent bronchial spasm following exposure to histamine aerosols, prevent lowering of blood pressure in animals, and have local anesthetic effects, as well as serve as brain excitants in large doses. But they cannot replace the treatment which consists of the elimination of the offensive protein and other substances that produce allergic reactions.

CRYSTALLINE PENICILLIN G PROCAINE IN OIL — This preparation consists of the crystalline procaine salt of penicillin G suspended in oil. Each cubic centimeter of the preparation contains 300,000 units of penicillin G chemically combined with 119 mg. of procaine base.

All those conditions for which penicillin is effective, especially in cases where frequently repeated injections are inadvisable or impossible. Included in the use of Crystalline Penicillin G Procaine in Oil in the treatment of all spirochetal diseases, actinomycosis,bacterial endocarditis and anthrax, prophylactically prior to dental extraction and tonsillectomy to prevent secondary infection, and as an adjunct to antisera in the treatment of colstridial infections and diphtheria.

Although Crystalline Penicillin G Procaine in Oil has not yet been used extensively, no reactions have been reported to date. It may be expected, however, that as its use is extended to a large number of patients a certain number of reactions may occur which will be similar to those encountered following the use of other forms of penicillin. Some reactions to penicillin are thought to be due to the drug itself rather than to associated impurities, or to the vehicle since these reactions follow administration of the pure crystalline penicillin as well as that of the amorphous material.

PROCAINE SENSITIVITY: The rare possibility of dangerous procaine reactions should be kept in mind. The symptoms are anxiety, sudden fainting, pallor, dyspnea, brief convulsions and arrest of respiration. The treatment includes lowering the patient's head, artificial respiration if necessary, and injecting intravenously some short-acting barbiturate (such as pentobarbital sodium, 3 to 7 grains), which has been reported to act as an antidote. Morphine and epinephrine are to be avoided in these reactions.

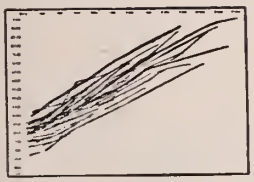
Mothers

APPRECIATE THE SIMPLICITY OF PREPARING FEEDINGS

The preparation of Similac feedings requires only the addition of Similac powder to previously boiled, tepid water—in the proportions you prescribe. Mixing requires only 20 to 30 seconds. The simpler your directions to the mother, the less chance of error on her part. And simpler procedure in preparing feedings makes sanitation easier.

Physicians

LIKE THE UNIFORM RESULTS



Similac is simple to prepare . . . Modern . . . Ethical. It gives uniformly good results.

ACCEPTED AMERICAN MEDICAL ASSN Council on Foods and Nutrition

A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

SIMILAC *Similar to breast milk*

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The National Auxiliary will hold its annual meeting during the annual session of the American Medical Association in Chicago, June 21–25. A most cordial invitation is extended to all women who are Auxiliary members or guests of physicians attending the convention to participate in all social functions and attend the general sessions. Whether Auxiliary members or not, the wives of doctors will be most welcome.

Auxiliary headquarters will be on the mezzanine floor of the Hotel La Salle. All meetings and functions will be held at the Hotel La Salle unless otherwise stated in the program or announced during the meeting. Please register early and obtain your badge and program of the social function.

All tickets should be purchased soon after arrival. These will be sold at the Auxiliary headquarters. All meetings and social affairs will begin at the time scheduled. Please be prompt.

Registration Hours

Sunday	2:00 p.m. to 4:00 p.m.
Monday	9:00 a.m. to 4:00 p.m.
Tuesday	9:00 a.m. to 4:00 p.m.
Wednesday	9:00 a.m. to 4:00 p.m.

PROGRAM

Sunday, June 20, 1948

Pre-Convention Meetings

Monday, June 21, 1948

4:00 p.m. Tea for the president, Mrs. Eustace Allen, and Mrs. Luther H. Rice, president-elect. Tickets $1.25. All doctors' wives cordially invited.

Tuesday, June 22, 1948

9:00 a.m. Business meeting. Address of welcome, Mrs. John Soukup, immediate past-president of the Woman's Auxiliary to the Illinois State Medical Society. Address of the president, Mrs. Eustace A. Allen.

12:00 p.m. Luncheon in honor of the past presidents of the Auxiliary. Tickets $3.50. Guest speaker: Dr. Morris Fishbein.

2:00 p.m. Business meeting and round-table discussion.

8:00 p.m. Open meeting of the American Medical Association. Grand Ballroom. Hotel Stevens. Members of the Auxiliary and guests are welcome.

Wednesday, June 23, 1948

9:00 a.m. General session and reports of the state presidents.

12:30 p.m. Annual luncheon in honor of Mrs. Eustace A. Allen, president, and Mrs. Luther H. Rice, president-elect. Tickets $3.50 (nineteenth floor). Guests of honor: Dr. Edward L. Bortz, president; Dr. R. L. Sensenich, president-elect; Dr. J. J. Moore, treasurer; Dr. George F. Lull, secretary and general manager; Dr. Morris Fishbein, editor of the *Journal of the American Medical Association* and *Hygeia;* and the members of the Advisory Council to the American Medical Association.

2:30 p.m. Business meeting.

Thursday, June 24, 1948

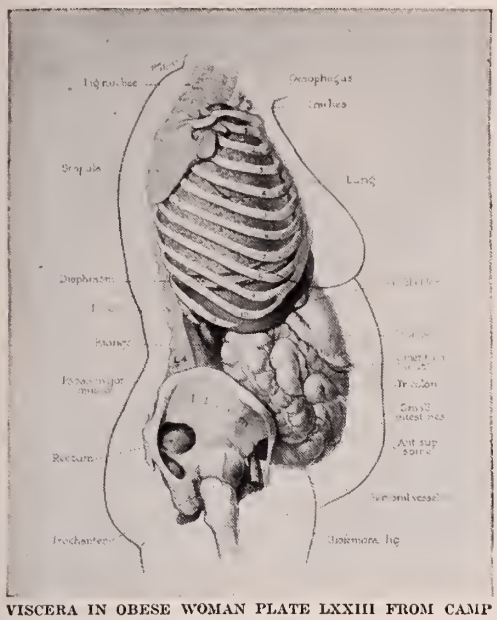
9:30 a.m. Meeting of Board of Directors.

6:30 p.m. Annual dinner of the Woman's Auxiliary for members' husbands and guests, Grand Ballroom, nineteenth floor. Tickets, $4.00.

9:00 p.m. Reception and ball in honor of the president of the American Medical Association, Palmer House.

Friday, June 25, 1948

Exhibits at Navy Pier.



VISCERA IN OBESE WOMAN PLATE LXXIII FROM CAMP ANATOMICAL STUDIES FOR PHYSICIANS AND SURGEONS

CAMP

ANATOMICAL SUPPORTS
for
PENDULOUS ABDOMEN

The adjustment of the Camp Support lays a foundation about the major portion of the pelvic girdle. From this foundation, the upright sections of the support hold the load up and back and give excellent support to the lumbar and lower dorsal regions.

The holding of the load furnishes not only relief to the spine but also lessens the drag of the viscera upon the diaphragm.

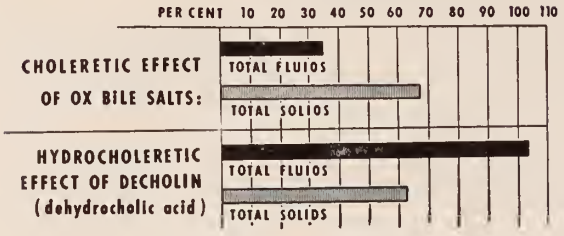
Photographs—Obese patient with 3rd degree pendulous abdomen and arthritis of the spine before and after application of abdominal and breast supports. (Skeletons indrawn.)

S. H. CAMP & COMPANY • Jackson, Michigan • *World's Largest Manufacturers of Scientific Supports*

Offices in CHICAGO • NEW YORK • WINDSOR, ONTARIO • LONDON, ENGLAND

Prescribe Journal-advertised products and you prescribe the best.

DECHOLIN HYDROCHOLERESIS Encourages Biliary Tract Drainage



● Percentage Increase in Composition and Quantity of Bile Flow

Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

HYDROCHOLERESIS—

an increased production of thin liver bile—is a desirable approach to therapy of non-obstructive biliary tract disturbances.

DECHOLIN—

by producing an increased flow of bile—washes stagnant, infected bile from the intrahepatic and extrahepatic biliary passages, removing pus-laden material and discouraging the ascent of infection.

HOW SUPPLIED:

Decholin in 3¾ *gr. tablets. Packages of* 25, 100, 500 *and* 1000.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

AMES COMPANY, INC.
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SOCIETY PROCEEDINGS

Ashland—Bayfield—Iron

On Monday, April 4, the Auxiliary to the Ashland–Bayfield–Iron County Medical Society met with the Monday Club to hear Dr. Franklin Smiley. Doctor Smiley is consultant in health and physical fitness of the Bureau of Health Education, American Medical Association. The subject of his talk was "Looking Ahead in Medicine."

Dane

The Auxiliary to the Dane County Medical Society met on April 13 for a dessert luncheon at the home of Mrs. Sverre Quisling. At the business meeting, Mrs. Sture Johnson, chairman of the Philanthropic Committee, gave her report of the year. One hundred dollars was voted by the organization at the beginning of the year for the purpose of purchasing needful articles for the Loan Closet. Through the efforts of Mrs. Johnson, three wheel chairs, one chair on wheels, two hospital beds complete with mattress and springs, seven mattress covers, and one high chair were purchased through the army surplus supply company. These items were gratefully accepted by the county nurses for use in their work.

Fond du Lac

The April meeting of the Auxiliary to the Fond du Lac County Medical Society was held at the home of Mrs. A. M. Hutter. Mrs. J. S. Huebner, legislative chairman, discussed current medical legislation of state and national importance and reviewed both the Wisconsin Plan and the Wisconsin Physicians Service plan. Mrs. L. C. Gardner, state chairman of the organization, reviewed the article "Dr. U.S.A."

Milwaukee

The March meeting of the Auxiliary to the Medical Society of Milwaukee County was held at the Knickerbocker Hotel on Friday, March 12.

One hundred and twenty-five members and guests attended the 12:30 luncheon. Mothers of the members were special guests. Richard S. Davis, famous *Milwaukee Journal* drama critic, fascinated his audience with his analysis of Broadway plays of the current season. A business meeting followed.

Polk

The Auxiliary to the Polk County Medical Society for some time has been gathering and compiling medical history data. This material is being prepared for the State Medical Society. At the March meeting, the interesting life and experiences of Dr. Mary Sorensen of Milltown was given by Mrs. J. M. Hammer of Milltown.

Outagamie

Members of the Auxiliary to the Outagamie County Medical Society met at the home of Mrs.

E. J. Zeiss at a dinner meeting. Plans were made for the May meeting at the Masonic Temple. Dr. Byron Hughes of Winnebago State Hospital will be the speaker.

Sheboygan

The March meeting of the Auxiliary to the Sheboygan County Medical Society was held at the home of Mrs. G. J. Hildebrand. After a business meeting, David Watson, boy soprano, entertained the group.

Washington—Ozaukee

Mrs. A. H. Barr of the Auxiliary and Mrs. W. H. Drissen have been collecting histories of the pioneer doctors in Ozaukee County for the past ten years. They have prepared a paper on this subject. Excerpts from this paper were given by Mrs. Barr at the Kiwanis meeting in March.

Winnebago

Members of the Auxiliary to the Winnebago County Medical Society and the Winnebago Dental Auxiliary were guests of the Winnebago County Medical Society at their regular meeting March 22 at the museum. Program feature of the afternoon was the reading of cuttings from the play "Christopher Blake" by Moss Hart, given by Mrs. Olive Davenport.

AS IT LOOKS TO YOUR STATE BOARD OF HEALTH

(Continued from page 485)

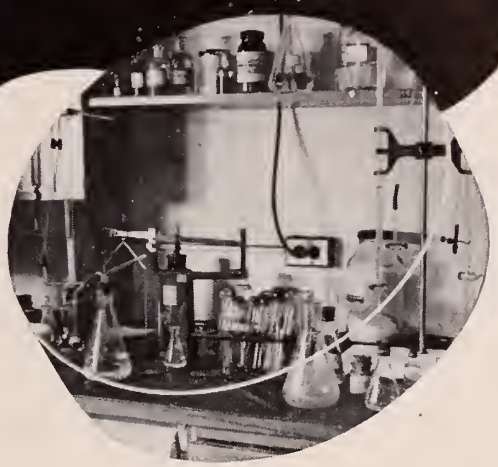
sonnel of the medical profession, can be used aptly to outline the heavy duty that has fallen to the lot of the profession during the past fifteen years.

Continued Heavy-Going Lies Ahead

Confronted by the foregoing birth totals, we do not need to invoke prophetic powers to see that the next ten years hold in store for Wisconsin and the nation some difficult problems of maintaining medical care as well as school facilities, housing, nutrition, and clothing, for when Wisconsin's annual birth average of 53,378 for the decade ending in 1941 suddenly increases to a range of 60,839 to 84,076 for the subsequent six years we are dealing not with problematic forecasts but with living residents of our youngest age groups.

The boom in the marriage rate has closely paralleled that in the birth rate. No wonder, then, that our state housing problem is acute. To what extent our newlyweds are delaying additions to the family circle is anyone's conjecture. The only certainty in the situation appears to be that it will require years to meet the various current demands.—PAUL WEIS, *Assistant State Registrar, Bureau of Vital Statistics.*

A LABORATORY TECHNIC IN A TABLET---



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A Primer of Cardiology. By George E. Burch, M. D., F. A. C. P., Associate Professor of Medicine, Tulane University School of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans; and Paul Reaser, M. D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. Pp. 272, with 203 illustrations. Philadelphia: Lea & Febiger, 1947. Price $4.50.

This text, while brief, is concisely, compactly, and clearly written. It places emphasis on the fundamental importance of basic anatomic and physiologic knowledge of the cardiovascular system, and a thorough work-up. Of necessity, because of the smallness of the text and the extent of the field, many of the statements are succint and dogmatic but without valid and generally acceptable. While the reviewer may not entirely agree with some of the authors' usage of terminology, conclusions, and methods of therapy, the short paragraph evaluation, for example, of the surgical therapy in hypertension is excellent in its summary. Those portions dealing with physical diagnosis are very good, as are the illustrations.

A study of this compendium will prove of benefit to the general practitioner and the student.—H. H. S.

Concise Anatomy. By Linden F. Edwards, Ph. D., Professor of Anatomy, The Ohio State University, Columbus, Ohio. Pp. 548, with 472 illustrations, some in color. Philadelphia: The Blakiston Company, 1947. Price $5.50.

This book occupies a position between the most elementary texts of anatomy and the relatively complete medical textbook. It will, doubtless, continue to supply the needs of students in physical education courses. It is well written and reasonably accurate in detail. The reviewer's opinion is that it is not complete enough, especially in illustrations, for students of subjects closely related to medicine.—O. A. M.

COMMENTS ON TREATMENT

(Continued from page 483)

than the leaf from which it is derived; and (*b*) in those instances in which it is advisable to switch a patient from one product to the other for psychologic reasons; (3) to have as his emergency preparation in the rare instances in which intravenous injection is needed the compound ouabain; and (4) to employ one of the older glycosidal mixtures when intramuscular injection seems unavoidable. — H. BECKMAN, M. D.

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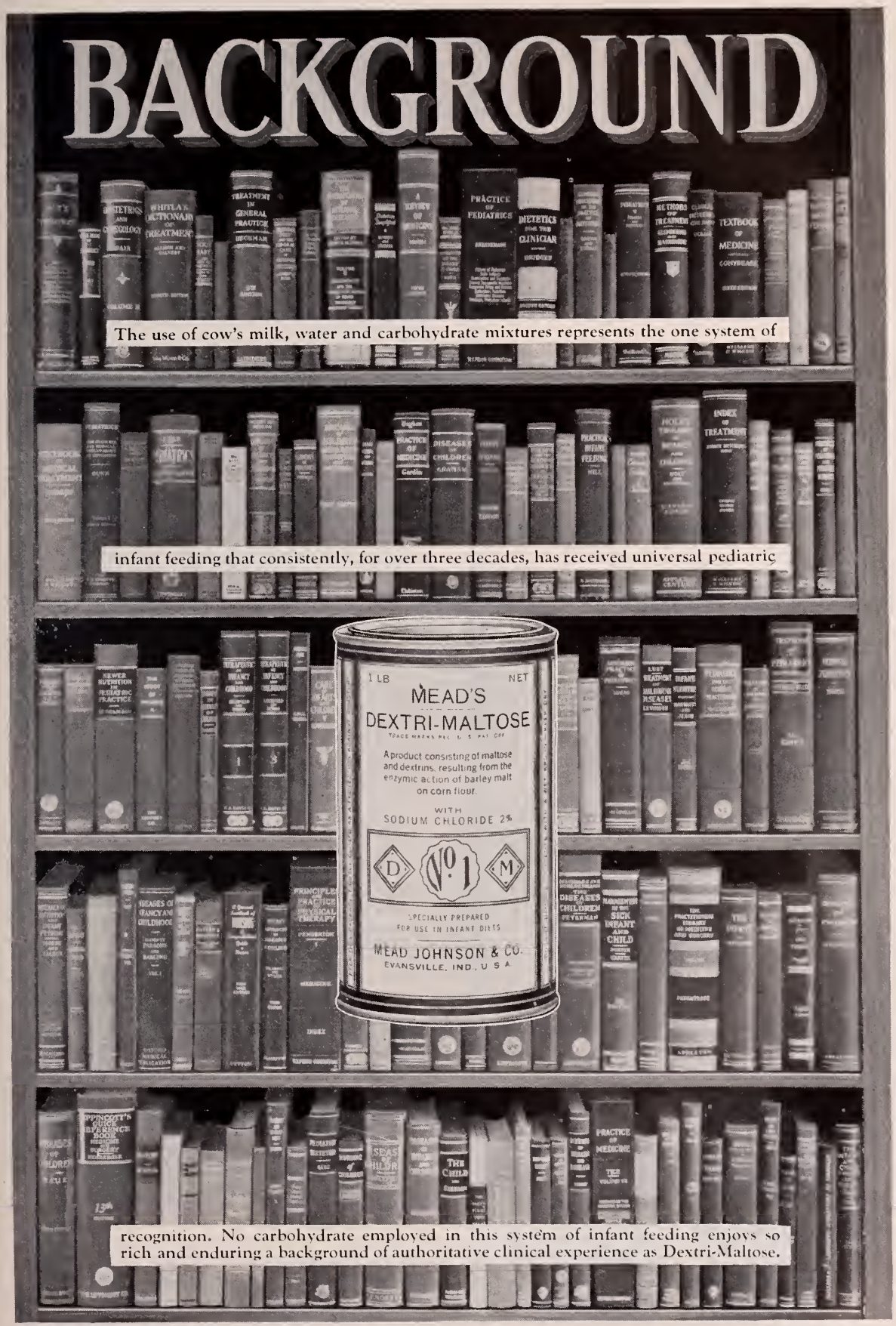
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REFERENCES
1. Jones, B. B.: Virginia Med. Monthly, 74:241, June, 1947.
2. Levine, S. Z.: J. A. M. A., 128:283, May 26, 1945.
3. Schroeder, L. J. et al: J. Nutrition, 32:413, Oct., 1946.

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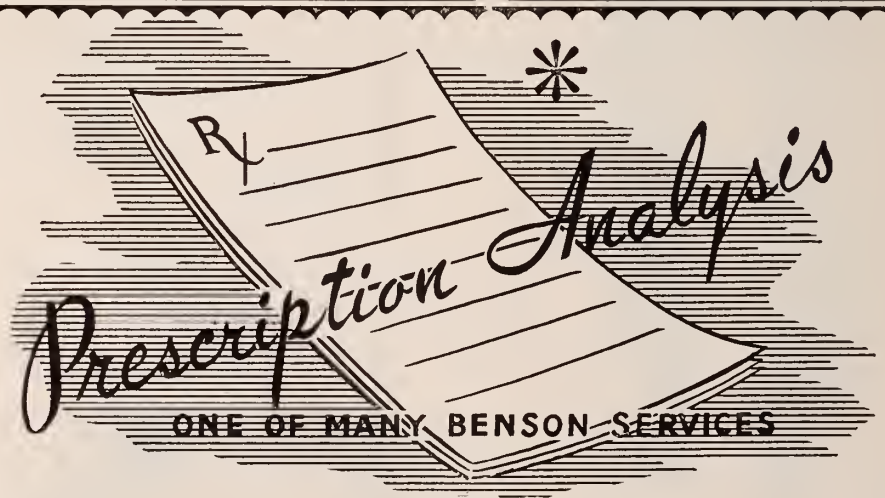

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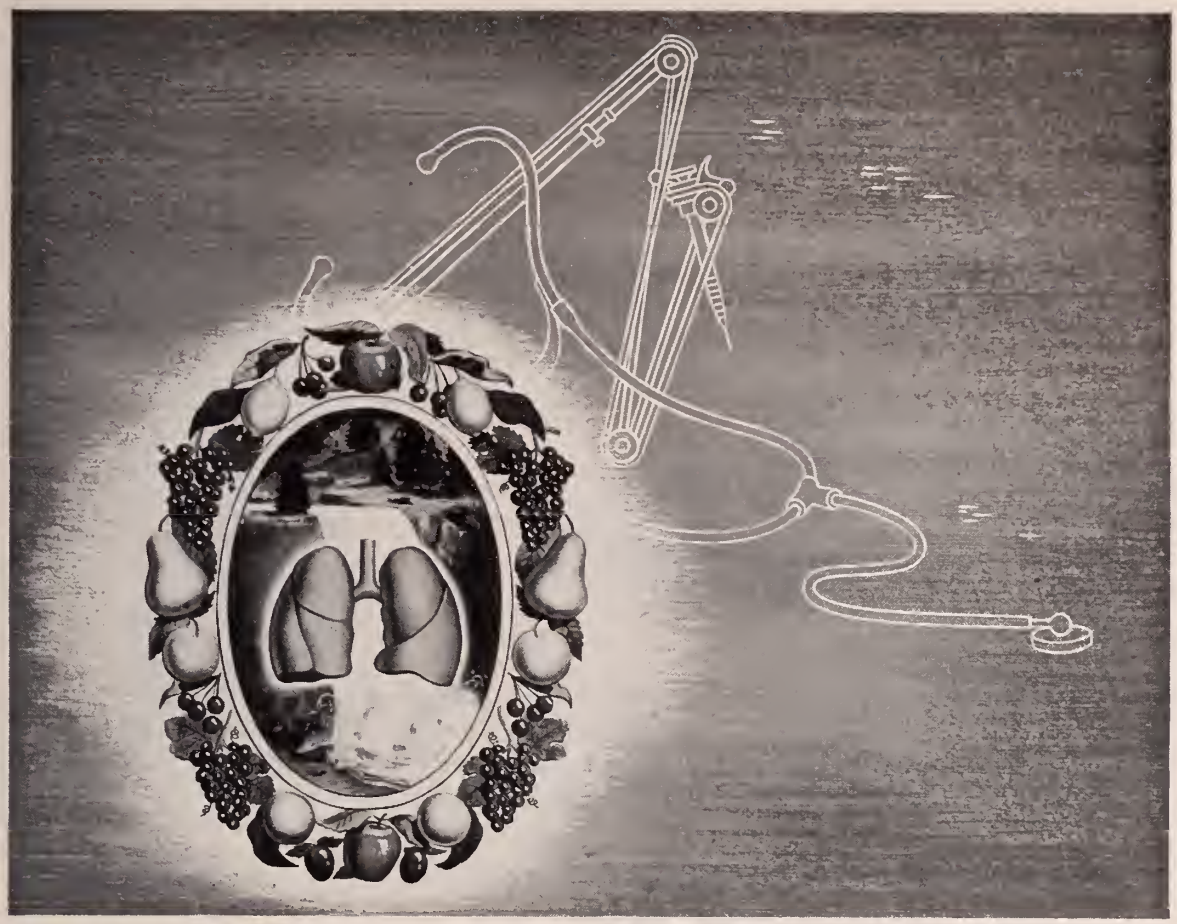

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Both Medicine and Dentistry thank Giovanni Morgagni of Padua (1682-1771) for studying the body's *abnormalities*, as Vesalius of Padua had studied its *normal* structure 200 years before. Morgagni watched *bodily changes due to disease*, as Sydenham had watched *symptoms*—and found, not Descartes' "misplaced soul juices," but changes "as natural as water running downhill." Pneumonia? Then the lungs would be "liver-red," not "fresh as a garland of fruit" (the symbol of health).

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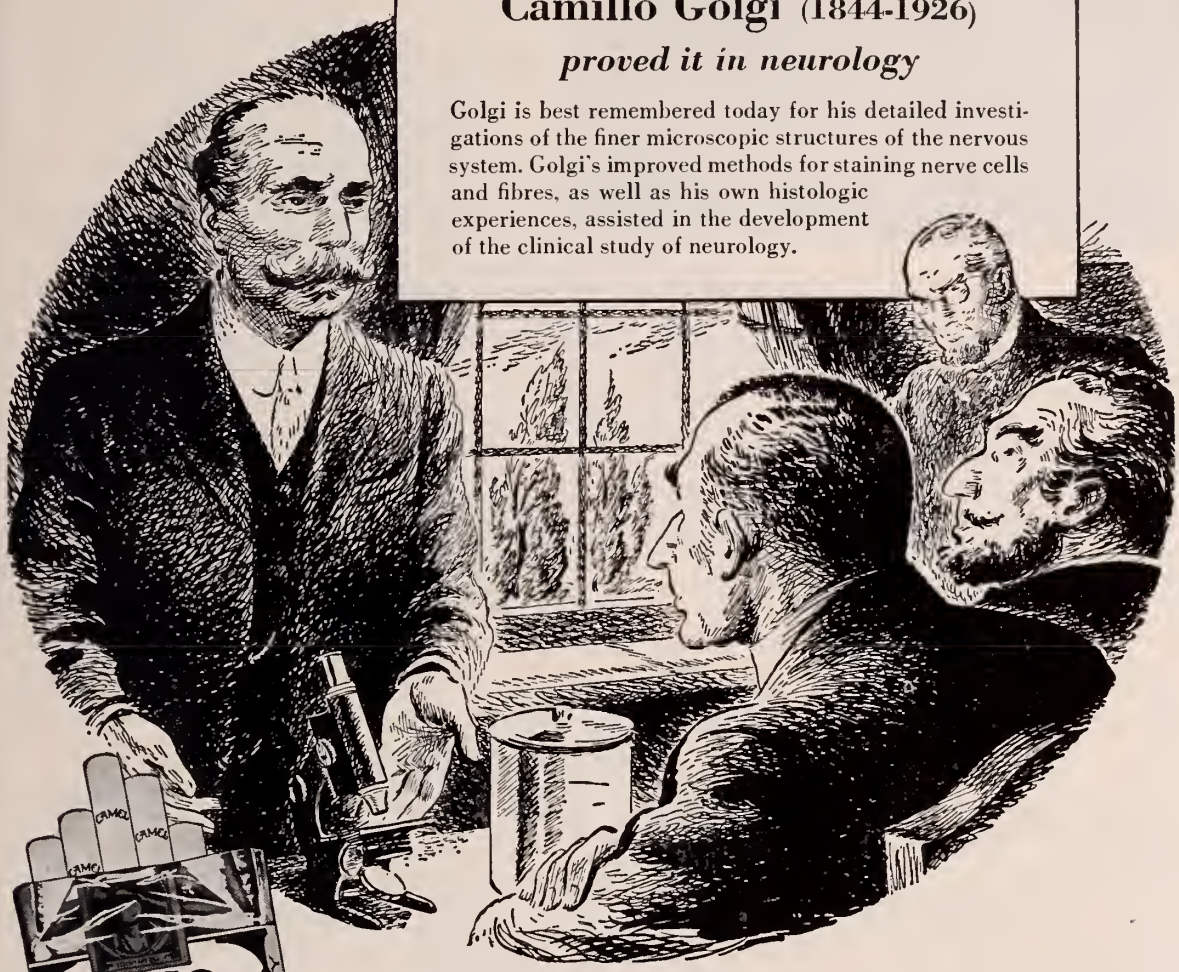

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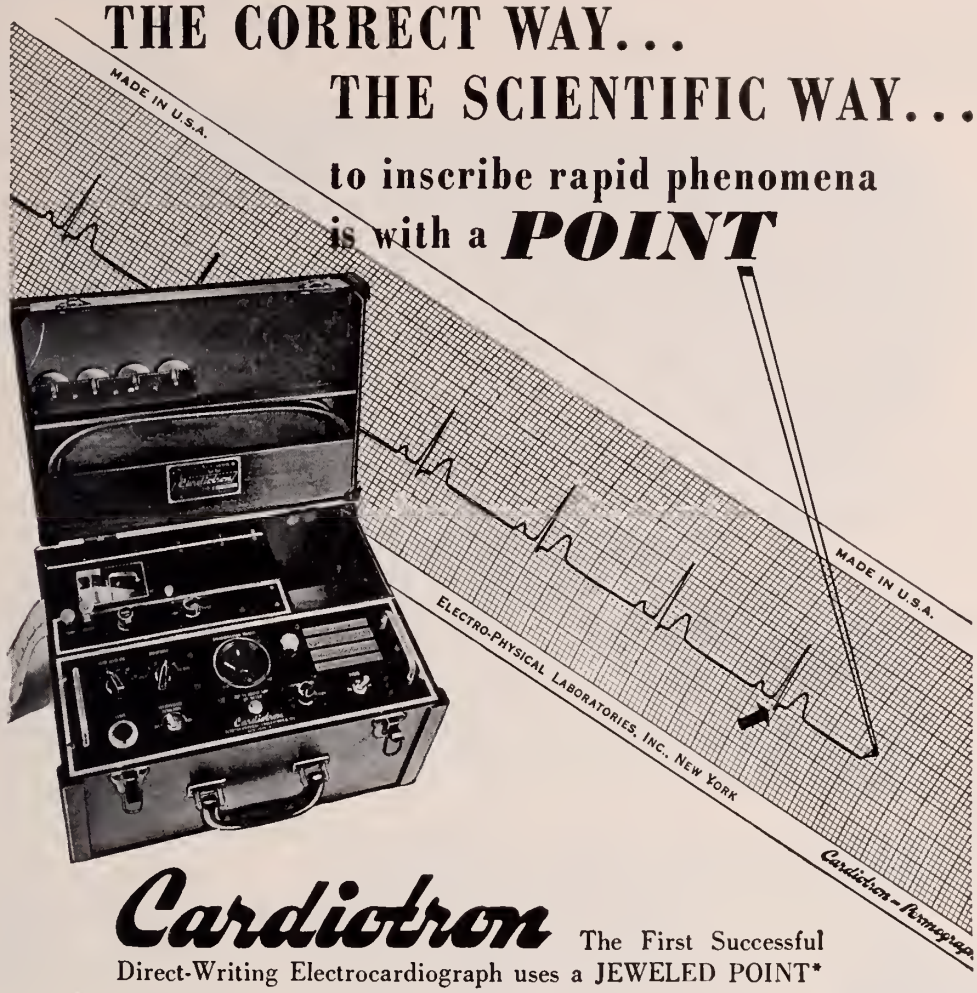

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No. 211 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

It is an accepted medical fact that excess weight can impair your health and efficiency, and possibly shorten your life.

One person's proper weight may be quite different from another's, however—even though their height and age are approximately the same. A large-boned, muscular person, for instance, should weigh considerably more than a small-boned person of the same height and age.

How much you should weigh is something to leave up to your doctor. Only your doctor can accurately judge whether your weight is within normal limits, or whether a loss or gain in weight is medically advisable.

If your doctor tells you that you weigh more than you should, it's just good sense to do something about it under his supervision. *To undertake a weight-reducing program without proper medical guidance is a foolish, and often dangerous, thing to do.*

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One type of pill, for instance, will cause you to lose weight—but only for a day or two! Its action is to remove water from body tissues, thus lowering your weight. But as soon as the water is replaced, the extra pounds are back again.

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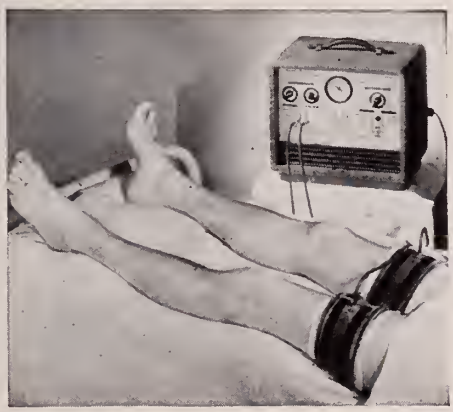

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	539
American Meat Institute	535
Ar-Ex Cosmetics, Inc.	524
Ames Company, Inc.	530, 531
Audiphone Utilities	547
Ayerst, McKenna & Harrison, Ltd.	451
Barlow–Maney Laboratories	456
Barr X-Ray Company	542
Bellevue Place	544
Benson Optical Company	536
Bergmann Prescription Center	540
Bilhuber–Knoll Corporation	540
Borden Company	534
Burroughs Wellcome and Company	452
Camel Cigarettes	541
Camp, S. H. and Company	529
Central Drug	526
Ciba	517
Cook County Graduate School of Medicine	542
Doerflingers	544
Drekmeier Drug	540
Eaton	525
Endocrine Laboratories	542
First Central Dispensary	540
Hotel Schroeder	544
House of Bidwell	542
Hurley X-Ray Company	547
Ivanhoe Treatment, Inc.	538
Jensen Brothers Prescriptions	526
Kennedy–Mansfield	546
Lilly, Eli and Company	facing page 463
Lov-é Brassieres	521
Luzier's Cosmetics, Inc.	453
M & R Dietetic Laboratories	527
Mallatt Pharmacy	540
Mather Pharmacy	526
Mayer Drug	526
Mead Johnson and Company	533, 550
Medical Protective Company	537
Milwaukee Optical Company	515
Milwaukee Sanitarium	552
Nechin, A. R. Company	543
Nestle's Milk Products, Inc.	457
New World Life Insurance Company	449
New York Polyclinic	547
Orthopedic Appliance Company	547
Page Milk Company	458
Parke Davis and Company	446, 447, 545
Philip Morris	450
Physicians and Hospitals Supply	462
Physicians Casualty Association	544
Physicians Radium Association	547
Pogue, Mary E. School	542
Prescription Pharmacy	540
Radium Emanation Corporation	448
Radium Service Corporation	544
Rennbohms	540
Rentschlers	546
Rexair	459
Rexall	551
Riggs Optical Company	538
Rogers Memorial Sanitarium	552
Sacred Heart Sanitarium	532
St. Croixdale Sanitarium	449
Schering	455
Schlintz Bros. Drug Store	526
Searle, G. D. and Company	513
Shorewood Hospital Sanitarium	515
Smith, Kline and French	454
Squibb	461
Summit Hospital Sanitarium	536
Upjohn	519
Webster–Chicago	548
Winthrop–Stearns, Inc.	523
Wyeth	460
Zemmer Company	522

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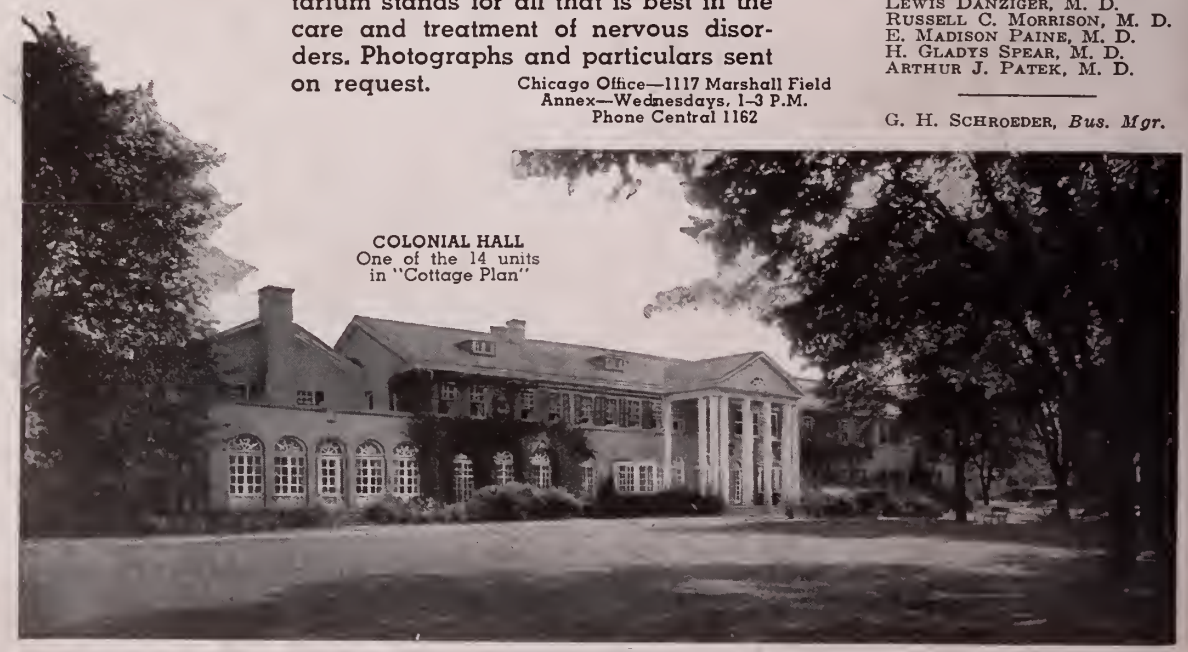

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
A Cardiac Function Test Based on Anoxia Induced by Rebreathing Air, by Arthur Andrews Holbrook, M. D., Milwaukee, and Herman H. Shapiro, M. D., Madison	571
Practical Aspects of Diagnosing Brain Tumors, by R. H. Quade, M. D., Neenah	583
Objectives in the Management of Children With Diabetes Mellitus, by Robert L. Jackson, Iowa City, Iowa	587
Protein and Amino Acid Utilization, by Otto V. Hibma, M. D., Madison	590
Occupational Medicine, Past and Present; As It Concerns Management, the Worker, and the Medical Department, Doctor, and Nurse Alike, by Elston L. Belknap, M. D., F. A. C. P., Milwaukee	594
The So-Called "Connell Suture," by F. Gregory Connell, Oshkosh	599
Comments on Treatment	602
Notes on Clinical Pathology	603
As It Looks to Your State Board of Health	604

EDITORIALS

	Page
Good Health and Healthful Living, by A. C. Sudan, Denver, Colorado	607
Tribute to Mary Byard Davis	618

MISCELLANY

	Page
The President's Page	605
As It Looks from the American Society of Anesthesiologists	608
Council Committee Appointments	617
Annual Meeting Announcements	
General Scientific Sessions	611
Obstetric Manikin Demonstrations	612
Clinical Conferences	613
Section Programs	615
Recent Wisconsin Licentiates	619
Society Proceedings	619
News Items and Personals	622
And About the Third and Twelfth Districts	624
Society Records	628
Births	628
Deaths	628
The Woman's Auxiliary	632
The Journal Bookshelf	634
Coming Events	642
Index to Advertisers	647
Physicians' Exchange	648
List of Executive Officers of County Medical Societies	649

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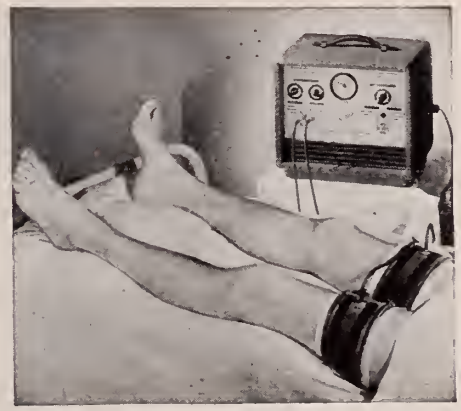

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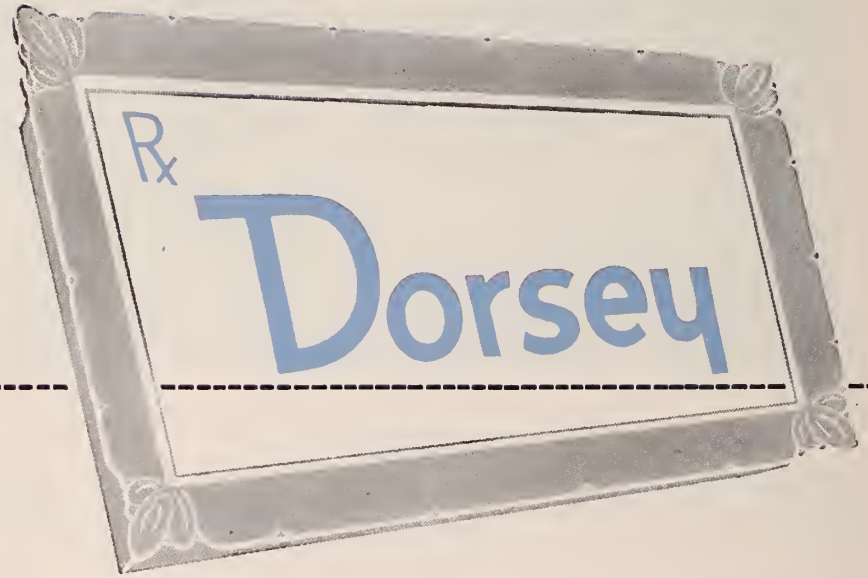

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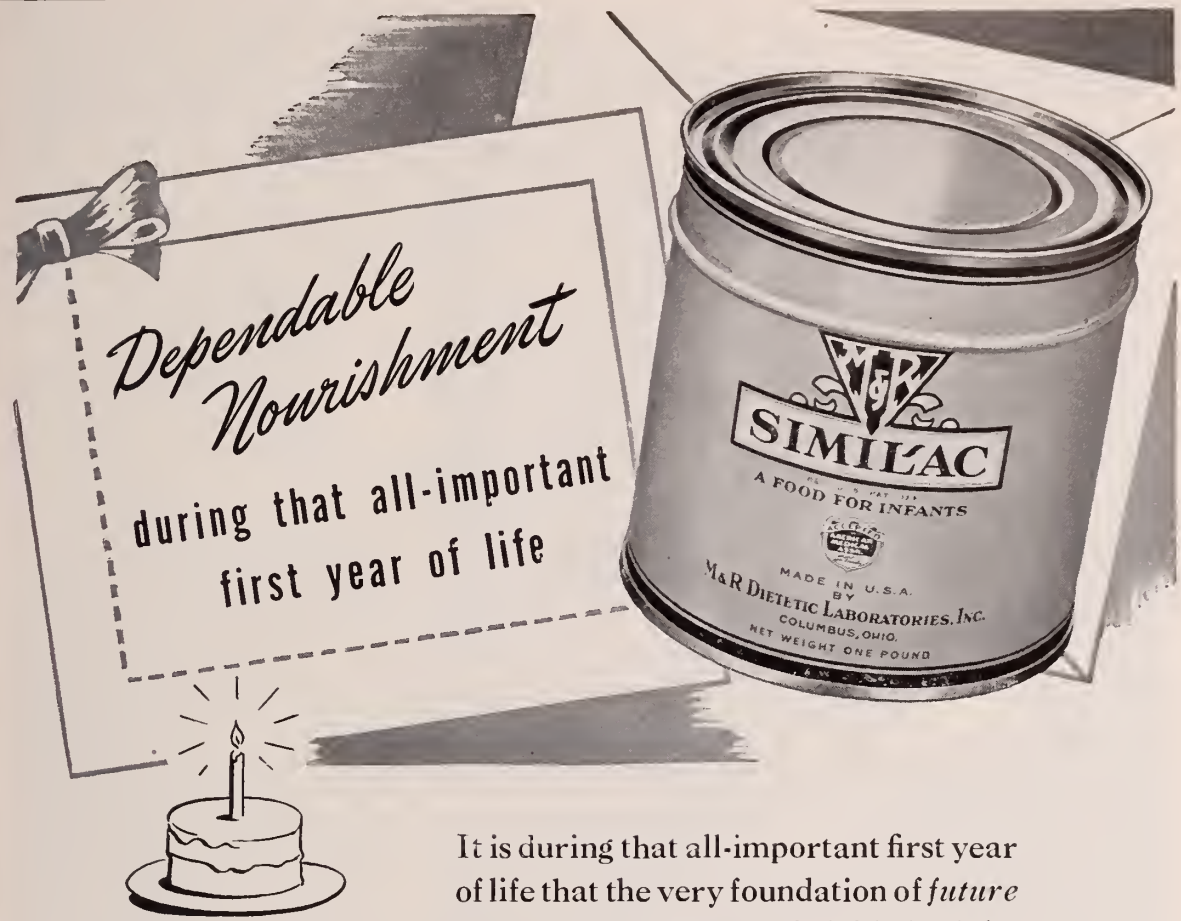

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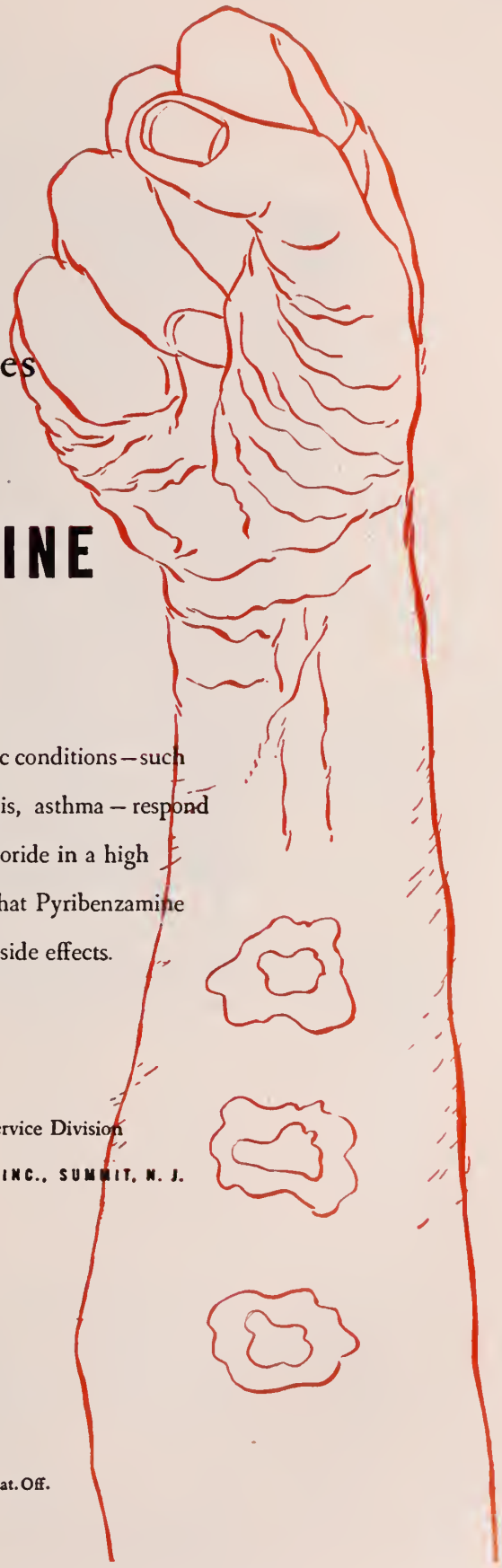

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Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934

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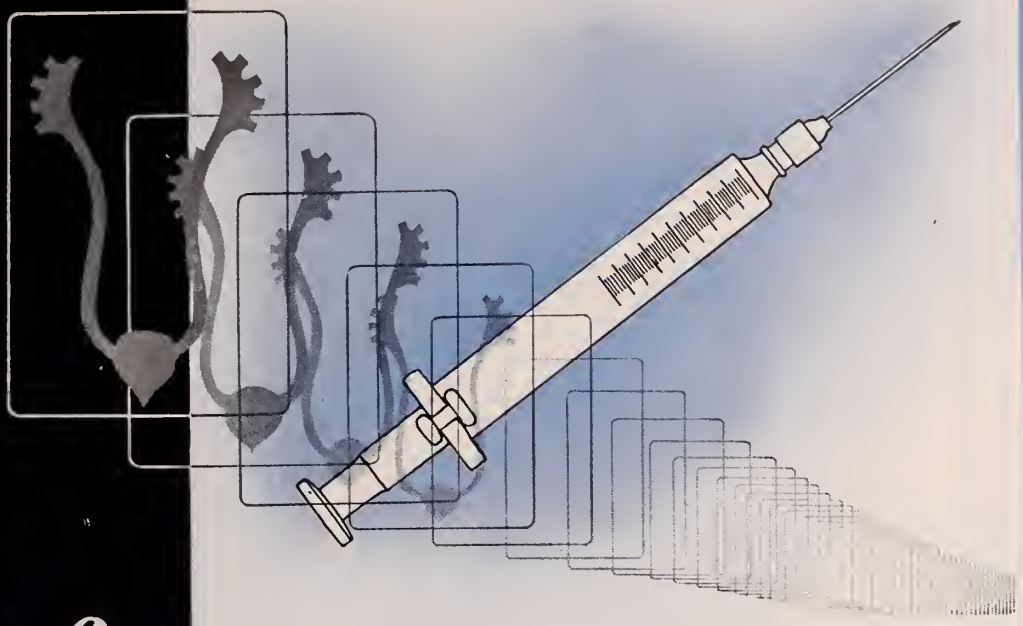

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3. Answer your doctor's questions *fully*. A previous illness may not seem to you to have any bearing on your present condition. But to your doctor it might furnish a valuable clue. Tell him complete facts. Let *him* decide what is important.

4. Follow your doctor's instructions *exactly*. If he prescribes medicine, take it *according to directions*. Remember, a larger dose than that prescribed won't cure you faster. And it might be harmful.

5. Never use medicine prescribed for somebody else, or for a previous illness of your own. However similar your symptoms may appear to you, the nature of your illness may be quite different. Only your doctor can accurately diagnose your trouble and prescribe proper treatment.

6. If your doctor advises an operation, don't put it off. With modern surgery, modern bospital care, you seldom have reason to fear an operation.

7. The new medical treatments you read about in the popular press aren't likely to be news to your doctor. If your doctor has not recommended a new treatment to you, it is probably because there are still some questions about its value, some limitations not stressed in popular reports, or some factors in your case which would make the treatment undesirable or ineffective for *you*.

8. Don't ask your doctor to advise you about members of your family whom he himself has not seen. He cannot risk giving an opinion about a patient of whose condition he has no firsthand knowledge.

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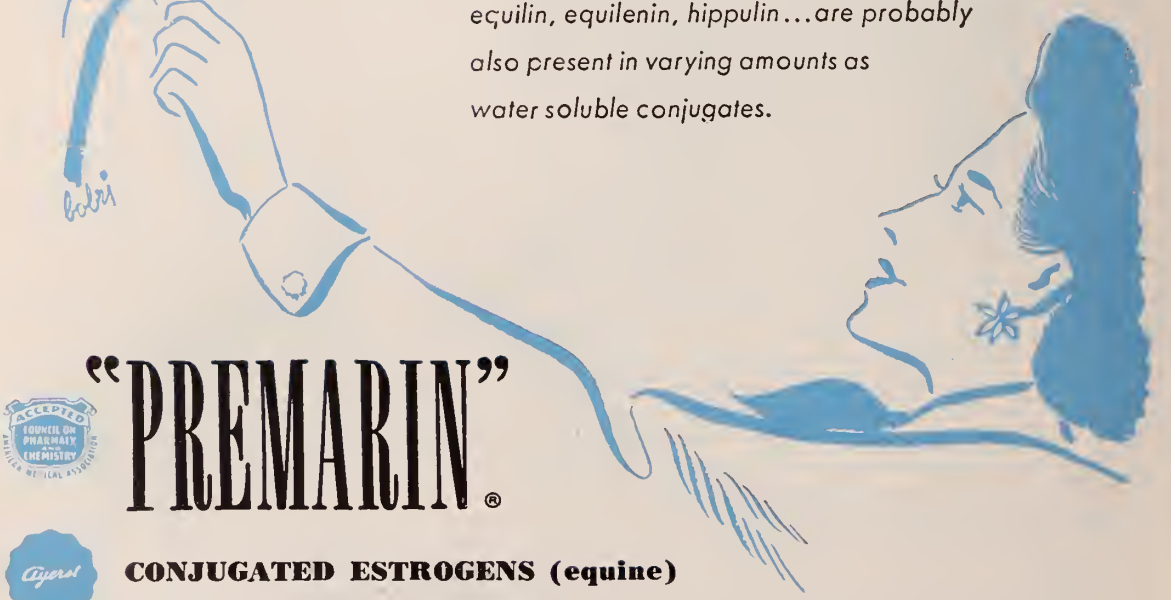

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A Cardiac Function Test Based on Anoxia Induced by Rebreathing Air*

By ARTHUR ANDREWS HOLBROOK, M. D. and HERMAN H. SHAPIRO, M. D.

Milwaukee *Madison*

A. A. HOLBROOK

A graduate of Harvard Medical School in 1932, Doctor Holbrook interned at Massachusetts General Hospital in Boston. In 1935 he joined the staff of Marquette University School of Medicine as clinical instructor in medicine. He served with the Army Medical Corps from 1942 to 1946, being separated with the rank of lieutenant colonel. At present he is in private practice in Milwaukee.

H. H. SHAPIRO

Doctor Shapiro received his medical degree from the University of Wisconsin Medical School in 1932. Entering the Army Medical Corps in 1942, he was separated in 1946 with the rank of lieutenant colonel. Doctor Shapiro is now assistant professor of medicine at the University of Wisconsin Medical School.

THIS is the first presentation of a study made in 1942 at an Army station hospital in Illinois. A considerable number of soldiers were being admitted there because of symptoms suggesting organic heart disease but lacking confirmatory evidence on physical and laboratory examinations. For the most part the cardiac service was satisfied with diagnosing the condition in these cases neurocirculatory asthenia. An occasional case, however, especially in the older age group, raised real doubt as to the justification of our putting it into the category of a functional disturbance. Consequently, the need for a cardiac function test was felt, and the stimulus for devising the one herein described arose.

The test is based on the principle that anoxia imposes a burden on any heart, the healthy heart tolerating the burden more efficiently than the heart crippled by inadequate intrinsic circulation due to whatever cause. It was found possible to obtain the same symptoms in bed as on the march simply by having the patient rebreathe room air from a basal metabolic respirator. As the oxygen tension in the allotted air was reduced, there usually developed in the subjects whatever sensations they characteristically experienced on exertion. Those who had complained of pain in the chest volunteered in most instances that the rebreathing test brought on the identical discomfort. This applied also to symptoms of palpitation, breathlessness, and weakness. Individuals in the control series frequently described their sensations as those due to "hurry," namely, shortness of breath and faster heart action. Remarks were made such as: "It is like climbing up to a high eighteenth green on a hot day," "I felt pressed for air," and "It was as if I had run up a couple of flights of stairs." Thus, subjectively, the rebreathing test seemed to provide a satisfactory substitute for actual physical exertion. Objectively, it afforded a simple means of standardization and readily allowed the incorporation of electrocardiography to detect signs of coronary insufficiency.

The Technic of the Test

Before testing an individual, a careful history was taken and a physical examination made. The test began by having the patient lie down after a meal (usually the noon meal) and relax for at least one hour. Reading was permitted, sleep encouraged. He was then transferred to a bed in the testing room which was small, quiet, well ventilated, and subdued in lighting. Complete relaxation was maintained for at least a half-hour more. Then the electrocardiographic technician applied the electrodes, using a rubber strap around the chest to hold the precordial electrode in place over the apex of the heart. A four lead tracing was promptly made.

A few explanations and instructions were then given to the individual. He was told that he was

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

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about to have a breathing test and that all he had to do was to breathe in and out through his nose and mouth, avoid hesitations, and keep it regular as to speed and even as to depth. Assurance was given that he would be coached if necessary. It was emphasized that he must not move toward the end of five minutes, when the second electrocardiogram was to be taken. Without further ado, the face piece was fixed in place and tested for leaks.

The equipment used was an ordinary bell-type basal metabolic machine and a portable electrocardiographic unit.

The respirator was kept properly supplied with active soda lime, and the whole system was flushed out with room air just prior to each test. Before making the connection with the face piece, the bell was filled with room air to its full capacity of 4½ liters. When the ink marker had been adjusted and the timing motor started, the valve was turned to throw the subject's respirations into the system. The routine procedure was to allow the rebreathing to continue for five minutes and then take a second electrocardiogram. Short strips were made from all four leads easily within one minute so that the mask could be removed at the sixth minute. These arbitrary timings were based on the experience of the first few tests, in which volunteers carried on even up to eight and one-half minutes. The depth of cyanosis in these extended tests seemed greater than was to be desired. We felt, therefore, that to limit the rebreathing period was a wise precaution against possible untoward physiologic effects. Furthermore, this restriction tended to help standardize the method. As will be shown below, a number of individuals were allowed to rebreathe for closer to seven minutes than to six. These were among the earlier cases of the series. On the other hand, if a man became restless or prematurely cyanotic or showed labored respirations before five minutes, the test was discontinued either immediately or after an electrocardiogram had been quickly made. Occasionally the mask was removed before the fourth lead was taken. Cyanosis always occurred and always cleared promptly after a breath or two of room air. Oxygen was kept on hand but never had to be used. There were no reactions like fainting, mental confusion, nausea, visual disturbances, cold sweats, or convulsions. No patient objected to a second test. The test was never repeated on a given patient within twenty-four hours.

After the mask had been removed, the subject was complimented and requested to lie still for a little longer. In exactly three minutes, the third tracing was obtained to complete the test. The patient was then questioned as to any symptoms he might have experienced and when in the course of rebreathing they had occurred. If precordial pain and dyspnea were not mentioned, leading questions were asked. Some patients could estimate fairly accurately the length of time required for distress to develop. In many cases the onset of dyspnea could be spotted by an extra deep breath or quickening of respirations as recorded on the tracing. The technician in charge of this tracing could often mark a point on it and later ask the subject, for instance, why he had made a fist or had moved an arm just before the electrocardiogram was taken. The individuals were not requested to give signals of symptoms for fear the power of suggestion might vitiate the results.

The Results of the Test

The test was performed forty-two times on 33 individuals, 3 of them being tested three times and another 3, twice. The cases are divided on a clinical basis into five groups: normal controls (11); cardiovascular conditions (8), a miscellaneous group including cases of arrhythmia, physiologic murmurs, vasomotor instability, and hypertension; neurocirculatory asthenia (5); valvular heart disease (5); and coronary heart disease (4). The results of the tests are presented in two tables.

Table 1 gives the significant data on the respiratory phase of each test. The first column contains figures indicating the angles at which the base lines of the breathing tracings rose from the base line of the graph. The column headed "Last Minute Volume of Respiration in Liters" pertains to the quantity of the bell mixture inhaled during the final minute of the test, while the second electrocardiogram was being taken. The size of the number indicates the degree of hyperpnea before the mask was removed. The next two columns give the total times of rebreathing and the intervals from the start to the onset of symptoms. Notes on the symptoms are also included in the table.

The pertinent electrocardiographic findings are summarized in tables 2 and 3. Case 28 is now included in the group with coronary disease because of tests positive for coronary insufficiency. Each tracing was studied for the following items: rate, rhythm, axis deviation, PR interval, QRS complexes, RS–T segments, and T–waves. Comparison of the figures obtained before, during, and after rebreathing in individual instances and the series as a whole showed that a large part of the data contributed but little to the study. Hence, only those features which supplied definite contrasts have been organized in the accompanying tables.

Table 2 gives a statistical survey of all the RS–T segment and T–wave changes to the extent of at least 1 mm. The deviations listed under "During" are those found in the second electrocardiogram on comparison with the first ("Before"). The changes under "After" refer to the third electrocardiogram, which has also been compared with the first. Thus, if a number of millimeters is noted under "During" and a zero under "After," it means that whatever change took place at the end of rebreathing reverted to the original condition after breathing room air for three minutes. The RS–T segment deviations were all in the direction of depression except for 2 in the noncoronary group and 1 in the coronary

TABLE 1.—*Data on the Respiratory Phase of the 42 Tests*

Case No.	Angle of Ascent, Respiratory Tracing, Degrees	Last Minute Volume of Respiration, Liters	Total Span of Re-breathing, Min.	Span to Symptoms or Signs, Min.	Symptoms		
					Pain	Short Breath	Other
Normal Controls							
1	13	23.0	3.9	3.5	0	+	
2	12	31.3	6.0	5.0	0		Numbness Tingling
3	18	20.7	4.5	4.0	0	+	Restless
4	14	26.3	6.0	5.5	0	0	
5A	16	15.8	7.4	5.8	0	+	
5B	17	21.0	5.5	4.5	0	+	
6	17	17.7	5.5	4.7	0	+	
7	17	20.8	7.1	7.1	0	0	
8	16	14.3	6.3	5.3	0	+	
9	16	13.2	7.1	5.9	0	+	
10	14	11.6	7.5	6.5	0	0	
11	32	26.0	4.3	2.7	0	+	
Cardiovascular Conditions							
12	16	36.5	5.5	4.0	0		Tired
13	13	16.0	6.0	5.1	0	+	
14	17	25.0	5.8	4.4	0	+	
15	17	18.1	5.7	3.8	0	+	Palpitation
16	17	18.0	6.5	5.0	0	+	Dizzy and faint
17	19	19.2	6.0	4.0	0	+	
18	16	8.6	7.0	7.0	0	0	
19	21	16.8	7.0	6.0	0	+	
Neurocirculatory Asthenia							
20	15	17.1	5.0	4.0	0	+	Palpitation
21	15	17.6	6.0	3.5	0	+	
22A	15	15.3	8.0	7.5	+	+	
22B	15	22.4	8.5	8.0	+	+	
22C	17	21.2	6.7	6.2	+	+	
23	17	25.3	6.8	5.8	0	+	
24	20	20.3	5.5	4.0	0		Faint
Valvular Heart Disease							
25	17	15.0	3.8	2.5	0	+	
26	19	22.3	5.5	5.0	0	+	
27	16	15.8	5.9	4.7	0	+	
28A	16	13.4	7.0	6.0	0	+	
28B	13	21.3	5.3	3.3	0	+	
29	18	17.3	5.7	5.0	0		Palpitation Warmer
Coronary Heart Disease							
30A	17	22.1	4.8	2.3	+	+	
30B	18	17.2	5.5	4.2	0	+	
31A	13	17.8	7.1	5.2	+	+	
31B	15	22.9	7.0	6.0	+	+	
31C	22	13.5	3.7	1.1	+	0	
32	18	27.7	5.5	4.5	0	+	Faint, dizzy
33A	14	27.4	8.3	6.1	0	+	Restless
33B	16	15.6	8.0	6.5	0	+	
33C	23	41.9	6.2	5.0	0	+	Restless

TABLE 2.—*A Statistical Summary of the Significant Electrocardiographic Deviations in the Series of 42 Tests*

	RS-T Segment Changes, During		RS-T Segment Changes, After		T-Wave Changes, During		T-Wave Changes, After	
	Limb Leads	Chest Lead	Limb Leads	Chest Lead	Limb Leads	Chest Lead	Limb Leads	Chest Lead
31 Tests on 28 Patients Without Coronary Heart Disease								
Number of Deviations	4	1	1	0	16	18	3	9
Extremes (in mm.)	1	1.5	1	0	1 to 2.2	1 to 5	1 to 2.7	1 to 4
Averages (in mm.)	1	1.50	1	0	1.48	2.18	1.56	1.84
11 Tests on 5 Patients With Coronary Heart Disease								
Number of Deviations	3	7	0	5	7	9	1	5
Extremes (in mm.)	1 to 1.2	1 to 3.5	0	1 to 1.8	1 to 3	1.5 to 17.5	3.5	1 to 6
Averages (in mm.)	1.06	1.78	0	1.16	1.78	6.20	3.50	3.40

group. Similarly, the T–wave changes were toward inversion except for 5 instances in each group.

Table 3 presents actual measurements of T–waves for those tests in which that complex crossed the isoelectric line either from above to below, or vice versa. Again, only changes of at least 1 mm. were deemed significant. In determining the degree of T–wave reaction in this respect, the figures "Before," "During," and "After" were contrasted. The results are given in the far right hand column. The portion of diphasic waves taken for basis of comparison was that which made the greater difference in total excursion.

Interpretation of the Results

In a study of this type it would be ideal to have the benefit of direct gas analysis of respirator, lung, and blood samples. Facilities for such determinations were, unfortunately, not available. Thus, no measurement of the extent of anoxia obtained in a test could be made. Clinically, however, it seemed that toward the end of each test the depth of cyanosis was directly proportional to the degree of hyperpnea. Therefore, the last minute volume of respiration was considered a very crude index of anoxia.

The exact significance of the "Angle of Ascent in the Respirator Tracing" has not yet been discovered. As the contents of the bell are reduced, the recording needle rises on the graph. Leakage in the mechanical system was looked for routinely but rarely found. Incidentally, the gradient obtained in case 11 was so unusually steep that a second breathing test was done three months later, with practically identical results (31 degree angle). No explanation is offered for this marked variation from the mean.

On analyzing the figures in table 1 and all the kymograph tracings, no important difference in the performance of the test could be found between the group with heart disease (valvular and/or coronary) and those without heart disease. In other words, heart disease does not produce any characteristic findings in the spirometric portion of the test or in the time of appearance of symptoms. The particular features worth noting in this respect are organized in table 4. In conclusion, one might use the following round figures for judging the standardization of this test: the base line of the breathing tracing ascends at an angle of about 17 degrees; the last minute volume of respiration (amount inhaled) averages 20 liters; symptoms may be expected to appear within five minutes.

Since the spirometric determinations furnish no indication of changes which might signify heart impairment, interest becomes centered on the electrocardiographic findings. Table 2 reveals that the incidence and degree of RS–T segment deviations are far higher in the coronary group than in the noncoronary group. T–wave changes were 50 per cent more numerous in the coronary group, and those occurring in the fourth lead during rebreathing were on the average about three times as marked as those in the noncoronary group. It must be emphasized, however, that the so-called averages have only relative value, since tests were repeated more often on the patients with coronary disease. Furthermore, this series of tests is too small to warrant the establishment of numerical criteria for positive and negative results.

Finally, table 3 requires comment. Within the limits of the study as a whole, this table contains the most useful data by which the results of individual tests may be judged. It shows that the one feature in T–wave behavior which proves distinguishing is its crossing of the isoelectric line in one of the following ways: from upright to inverted, from inverted to upright, from either upright or inverted to diphasic, and from diphasic to either upright or inverted. In only four of the thirty-one tests on patients without coronary disease did this phenomenon develop, an incidence of 13 per cent; whereas, it happened in nine of eleven tests (81 per cent) within the coronary group. The average excursion of the T–wave peaks in these crossings was 1.4 mm. for the controls and 5.7 mm. for the coronary cases. Finally, it is particularly noteworthy that the T–wave transgressions in the noncoronary group occurred exclusively in leads II and III, whereas in 8 of the 9 instances in the coronary group T_4 was involved. It would seem, therefore, from the data thus far obtained that the passing of T_4 across the isoelectric line is the one definite criterion indicating coronary insufficiency.

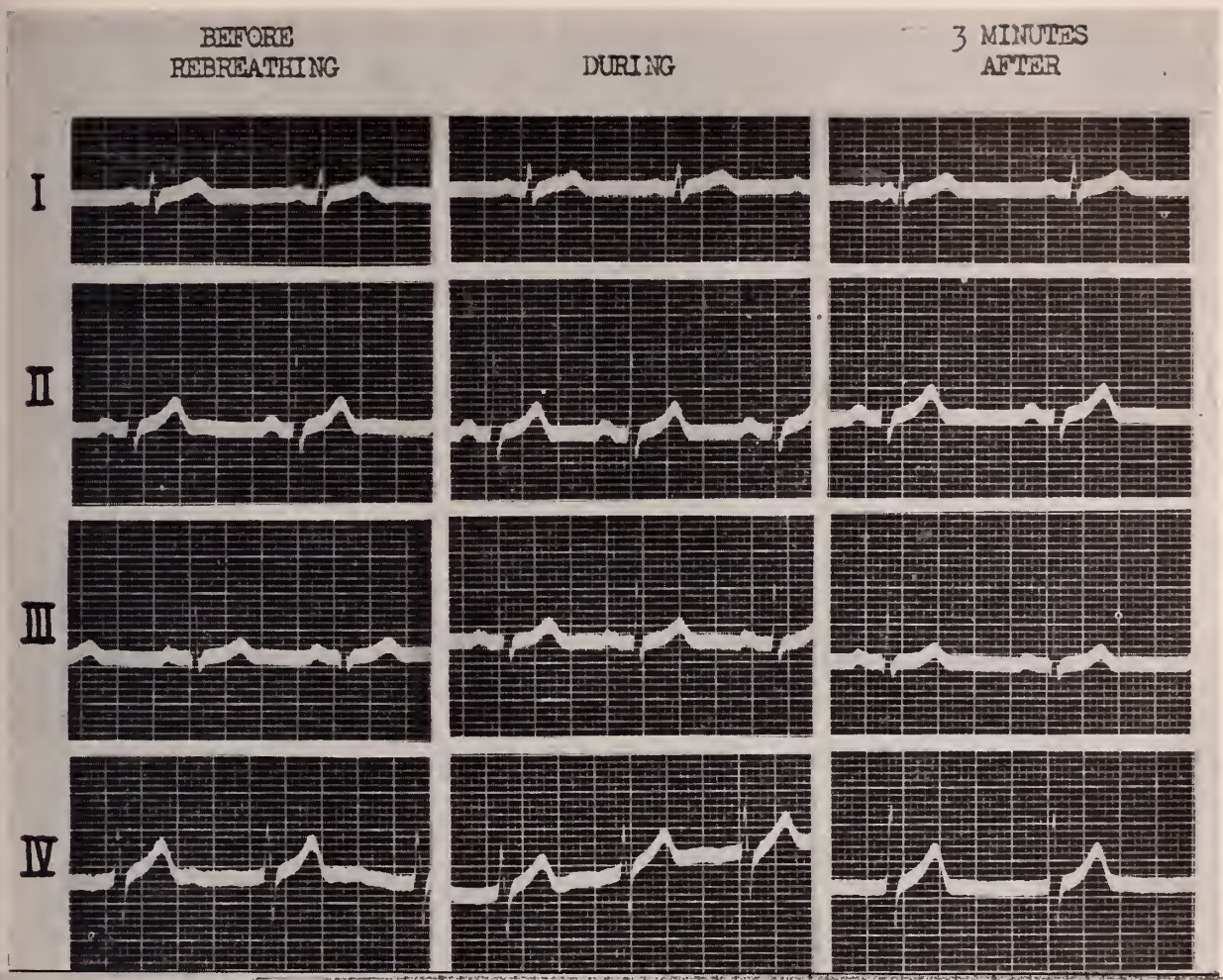
Examples of the Test

Case 18.—A man of 40 had been told a year before that he had a heart murmur. In our opinion it was a physiologic systolic blowing murmur without clinical importance. Both the accompanying spirometric graph and the electrocardiographic series are normal.

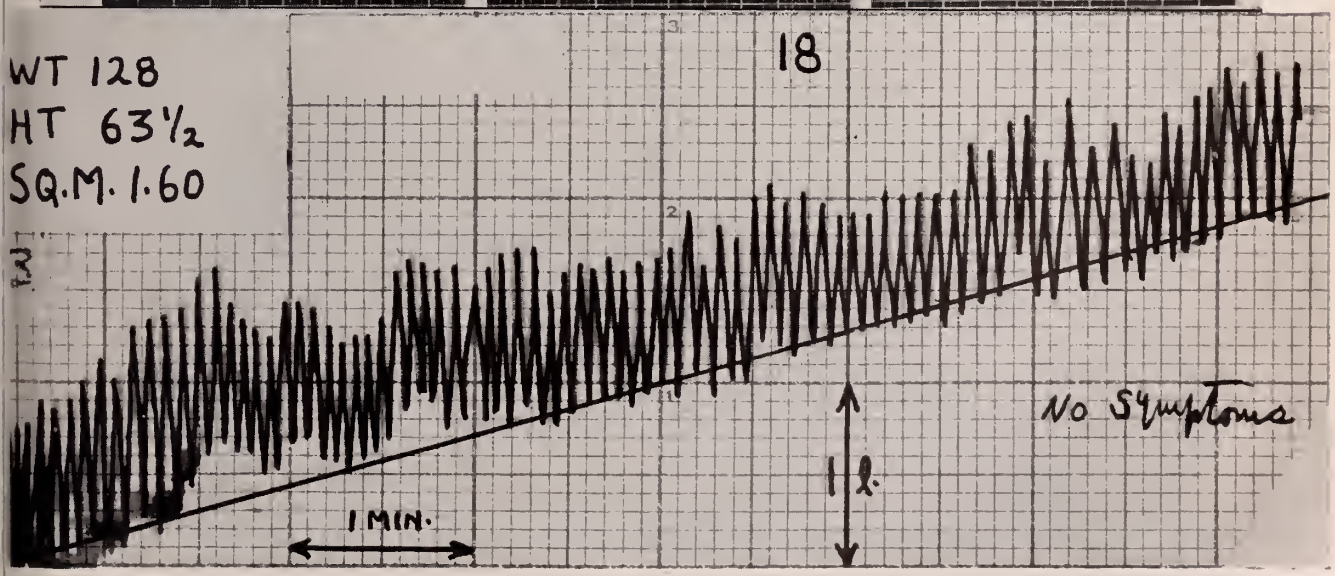
Case 5B.—A 30 year old soldier had chronic glomerular nephritis with slight elevation in blood pressure and a normal heart on physical examination. His pulmonary and cardiac tracings are also presented as examples of normal.

Case 28B.—A soldier was 43 years old and gave no history of rheumatic or luetic disease. Three members of his family had died from heart disease. Except for slight shortness of breath and pain in the chest on exertion, he had no complaints. Aortic insufficiency and cardiac enlargement were found. In doing the rebreathing test dyspnea developed in 3.5 minutes, which was 2.7 minutes earlier than during a previous test. The explanation for this discrepancy was not determined. The test was stopped after two more minutes because of cyanosis, and at that point the electrocardiogram showed little change. After three minutes, however, the T–wave in lead IV had become completely inverted from its upright position. According to the criterion this signified coronary insufficiency and thus added important evidence to our otherwise nonconclusive data. For this reason the case was transferred into the coronary group.

Case 31.—A 36 year old soldier gave the following important family history: his mother had died of a stroke and heart disease at 56, and an uncle (50 years) and brother had both died suddenly. The



A



B

Fig. 1.—Case 18. *A*, These electrocardiograms show no reaction to the induced anoxia. *B*, This tracing of respirations is considered normal, even though the last minute volume of respiration is the smallest in the series.

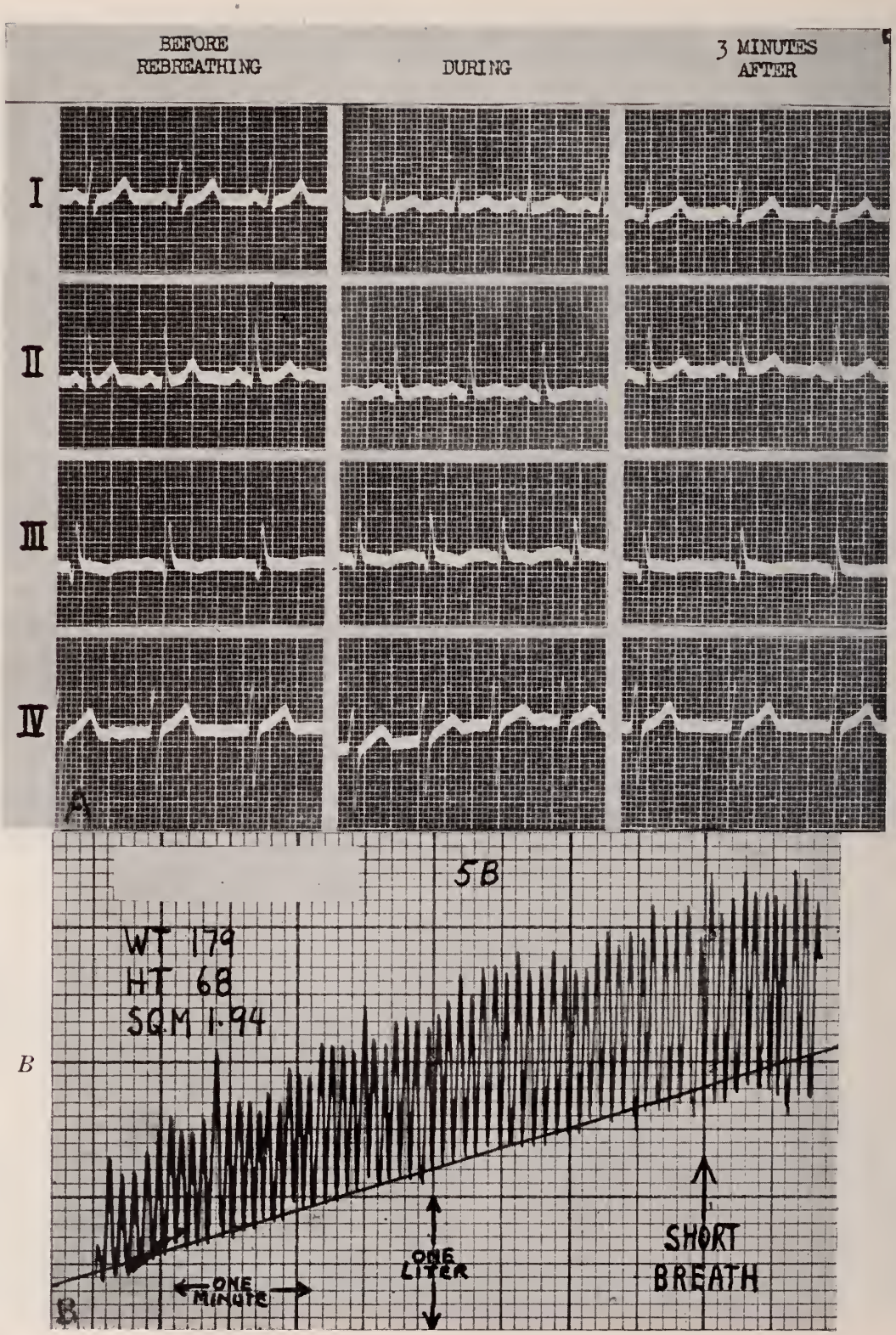


Fig. 2.—Case 5, test B. *A*, The changes occurring in the T waves in leads I, II, and IV of this test are considered within normal limits. *B*, This tracing is a good example of normal breathing behavior during the test in which the depth of respiration increases gradually.

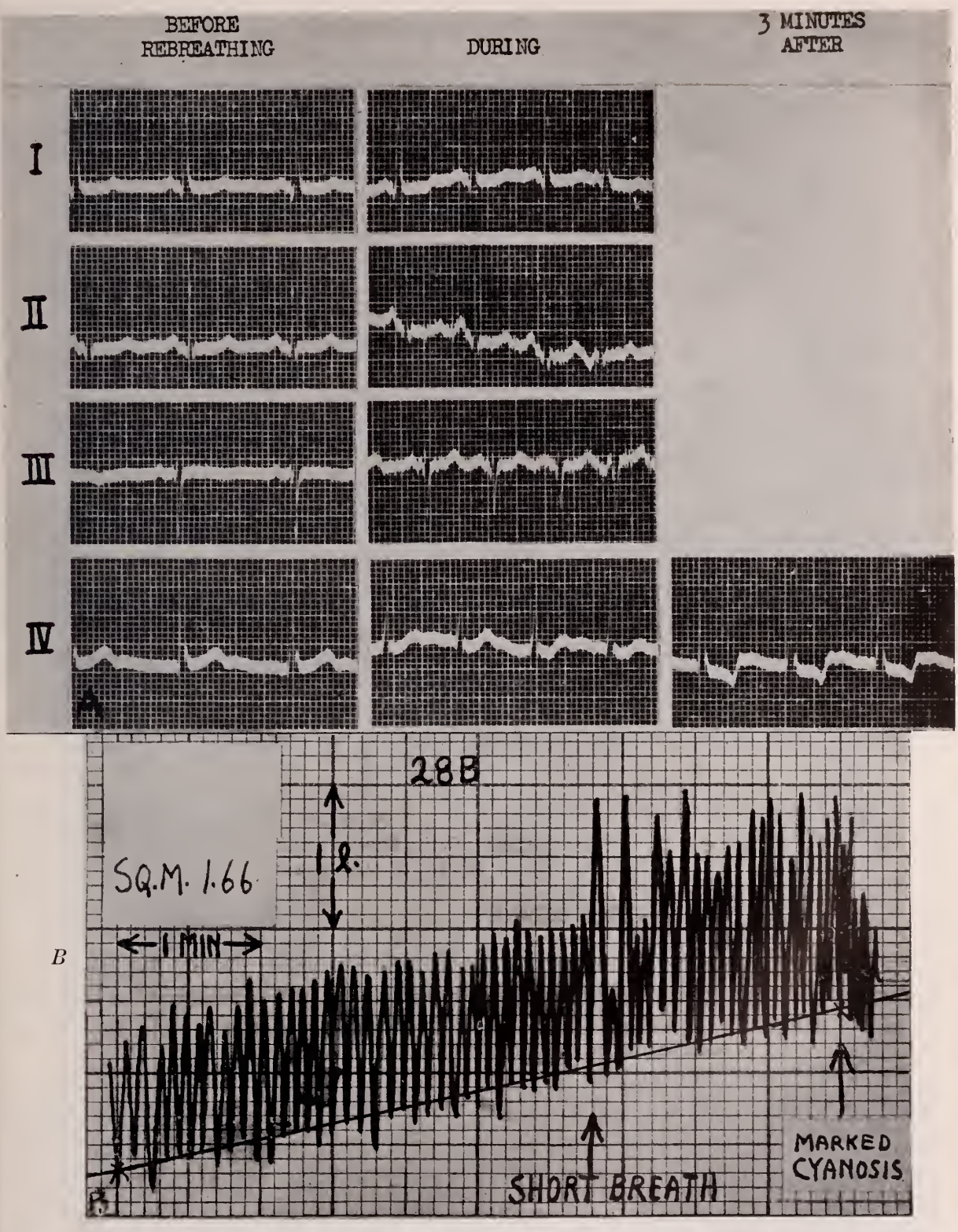


Fig. 3.—Case 28, test B. *A*, This series of tracings illustrates a delayed effect in which the most significant change appeared in T_4 three minutes after the mask was removed. *B*, This recording clearly shows the onset of dyspnea which occurred prematurely.

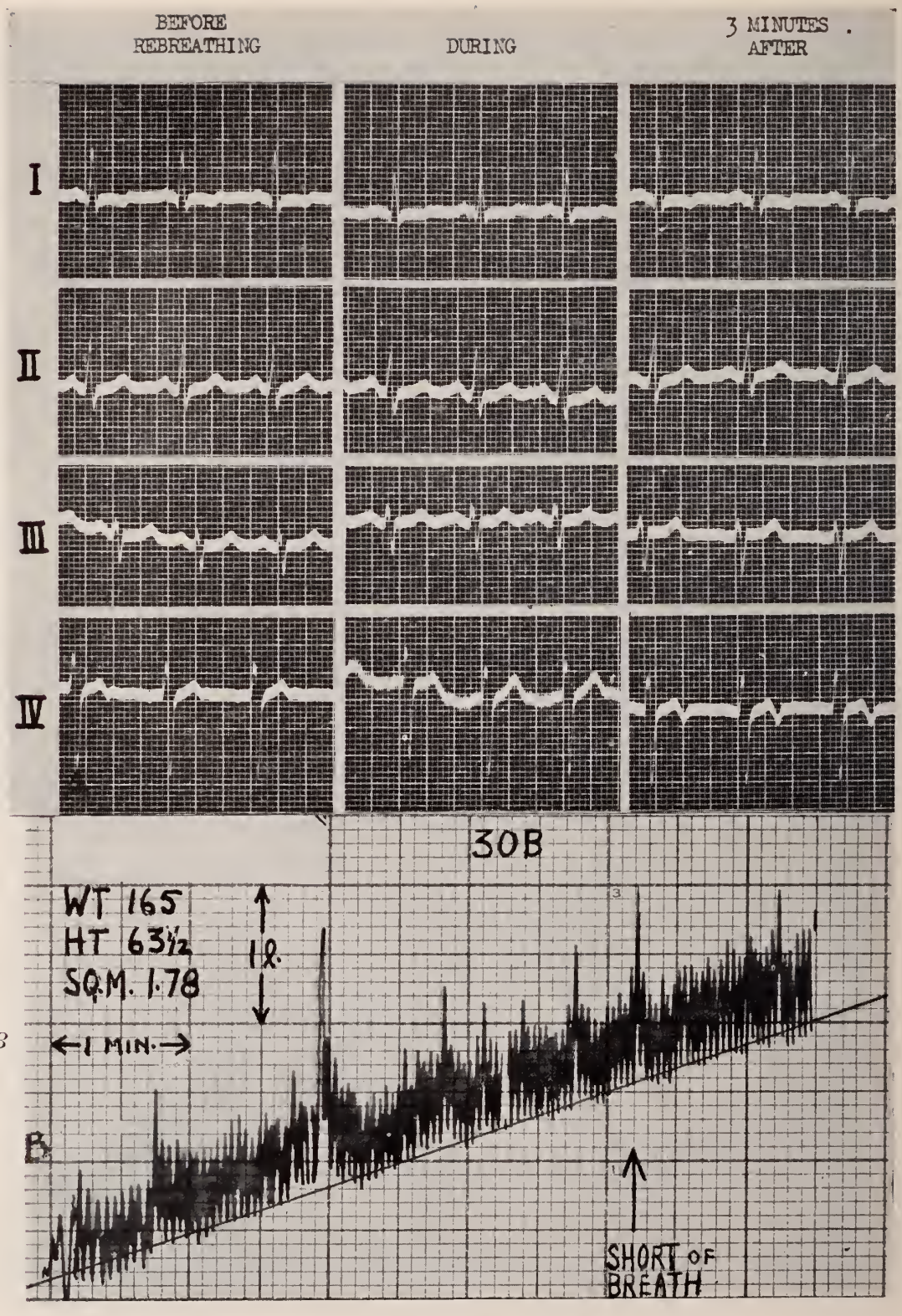


Fig. 4.—Case 30, test B. *A*, The changes of note in this test are the tendency toward flattening of T_1 and the development of an upright T_4. After three minutes the diphasic configurations are restored with even more definite inversion. *B*, This rebreathing test illustrates a common type of shallow respiration which is interspersed with deeper breaths. The point at which symptoms develop in these cases can be determined only by careful questioning of the subject.

TABLE 3.—*Instances in Which the T-Waves Crossed the Isoelectric Line*

No.	Case	Lead	Before	During	After	Degree
28 Cases without Coronary Heart Disease (31 Tests)						
1	6	II	+1.0	+0.5;—0.5	+0.8	1.5
2	14	II	+1.0	+0.5;—0.5	+1.8	2.3
3	21	III	—0.5	+0.5	+0.5	1.0
4	23	III	—0.5;+0.5	+0.5	----	1.0
5 Cases with Coronary Heart Disease (11 Tests)						
5	28B	III	—0.2	+1.0	----	1.2
6	28B	IV	+1.5	+1.0	—3.0	4.5
7	30A	IV	—2.0	+1.3	—1.0	3.3
8	30B	I	—0.6;+0.2	+0.3;—0.1	—0.8	1.1
9	30B	IV	+1.5;—0.5	+3.0	+0.5;—2.0	5.0
10	31A	IV	—4.0	—2.0;+1.0	----	5.0
11	31B	IV	—3.5	+1.5	+1.0	5.0
12	31C	IV	—3.0	1.5;+1.0	—2.3	4.0
13	33A	IV	+12.0	—5.5	----	17.5
14	33B	III	—0.5	+0.5	----	1.0
15	33C	IV	+13.0	+1.5;—2.0	+7	15.0

Minus (—): Below the isoelectric line (in millimeters).
Plus (+) : Above the isoelectric line (in millimeters).
Semicolon : The isoelectric line between the parts of a diphasic complex.
Degree : The total extent of the T-wave excursion throughout the test (in millimeters).

patient had had dyspnea, palpitation, and severe precordial pain on exertion. The physical examination revealed signs of arteriosclerosis but nothing remarkable about the heart. An electrocardiogram gave strong evidence of coronary disease. It was, therefore, important to know what change might be produced by the test. Test B reveals the typical sign of coronary insufficiency: the shifting of the T_4 peak across the isoelectric line. In this instance T_4 changed from an inverted to an upright state. The respiratory results were normal.

CASE 30B.—A 43 year old soldier complained of moderate dyspnea on exertion as well as precordial pain which radiated into the left arm. Hypertension, an accented aortic second sound, and a palpable liver were the only physical findings of note. The breathing portion of the test was not remarkable. The control electrocardiogram might well have been interpreted as suggesting a diagnosis of left ventricular strain, but the tracings "During" and "After" showed T_4 changes which were considered definitely indicative of coronary insufficiency. The sequence was more clearcut in test A, of which the fourth lead strips are here included.

CASE 33C.—This test furnished the most dramatic electrocardiographic changes in the series. The patient was a soldier of 43 who appeared seven years older. His sister, 39 years old, had high blood pressure; an uncle had sustained a stroke; and his mother had died at 32 of heart disease. His symptomatology was typically that of angina pectoris. However, the physical examination, an electrocardiogram, and fluoroscopy failed to establish a diagnosis of organic heart disease. Mild hypertension, bradycardia, a physiologic murmur, and signs of premature aging were the chief positive findings. An increased basal metabolic rate (25) was attributed to this patient's inability to cooperate, a feature which is apparent in the accompanying spirometric graph. Electrocardiographic deviations appeared in every lead on rebreathing and were most striking in lead IV, where the tall, upright T–wave crossed the isoelectric line. It was felt that this additional evidence made possible a diagnosis of coronary sclerosis.

Thus far, examples have been given of normal tests and instances in which abnormal results aided in making the diagnosis of coronary insufficiency. There were also cases in which the test helped to rule out this condition. It should be emphasized that negative results in particular must be interpreted with caution. Yet a negative test may not be worthless. If the procedure is well carried out and the various respiratory determinations run true to form, then a normal electrocardiographic series may properly be accorded positive value. For instance, case 22 was that of a 42 year old soldier who complained of heart trouble. He stated that until about two years before, he had done much cross country

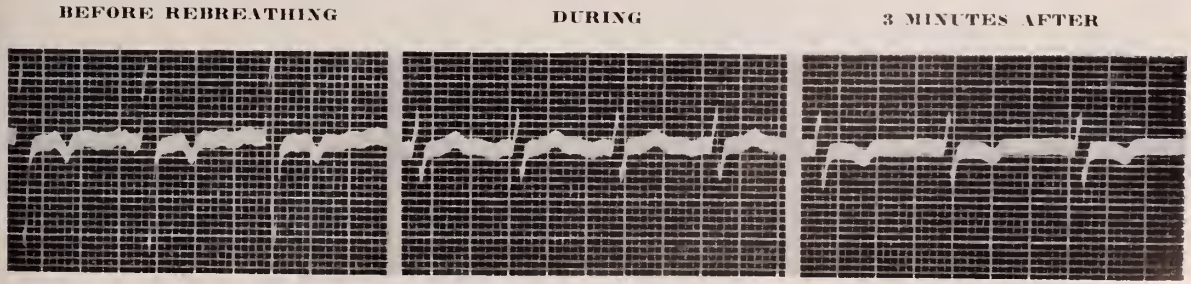


Fig. 5.—Case 30, test A. The same tendency is well demonstrated in this tracing from another test on the same individual.

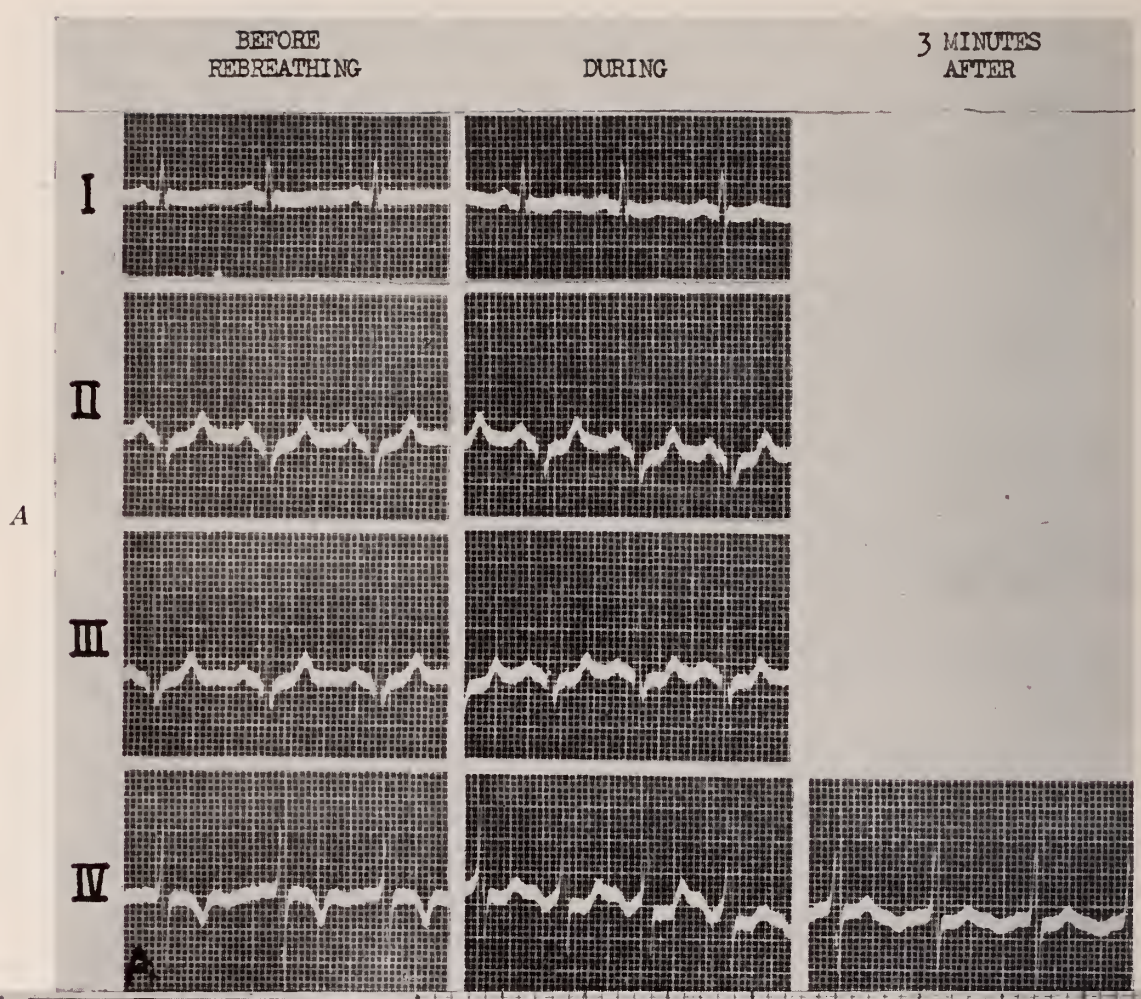


Fig. 6.—Case 31, test B. *A*, The significant features of this test are the reversal of T_4 from an inverted to an upright state and the persistence of the latter after the mask was removed. *B*, The breathing in this test was normal throughout in spite of the onset of pain toward the end. The hiatus in the tracing was due to the ink marker's becoming disengaged.

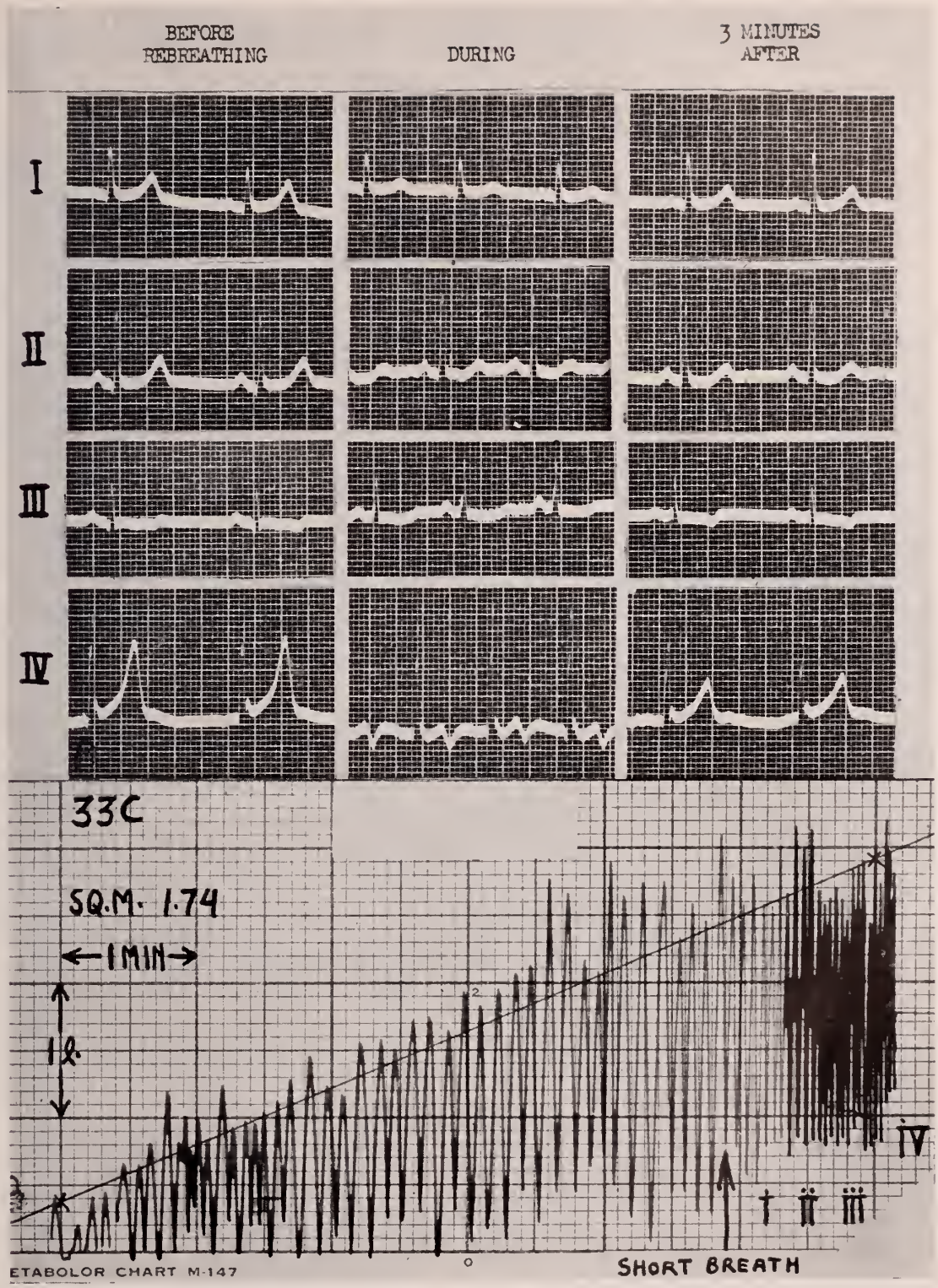


Fig. 7.—Case 33, test C. *A*, This test reveals the most striking changes in the whole series. The control electrocardiogram is within normal limits, although the peaking of T_1 and T_4 might be questioned. After rebreathing, RS-T_2 becomes slightly depressed and slopes downward; RS-T_3 becomes moderately depressed; T_1 falls to less than 1 mm., and T_2, T_3, and T_4 become diphasic. After three minutes these changes are no longer evident. *B*, This recording was made by a patient who could not control his respirations. Between the taking of Leads III and IV, his breathing was so labored that the mask was removed.

running and that his symptoms had come on not long after he had dropped that strenuous sport. He complained of shortness of breath, palpitation, and pain in the chest on exertion. The pain was "knife-like," arose beneath the left nipple, and radiated both across the chest and into the left arm. It was not squeezing in nature and yielded quickly to rest.

TABLE 4.—*The Averages of the Significant Figures in Table 1*

	Angle of Ascent Respirator Tracing, Degrees	Last Minute Volume of Respiration, Liters	Span to Onset of Symptoms or Signs, Minutes
Group without heart disease (averages for 27 tests on cases 1 to 24)	16.8	19.9	5.1
Group with heart disease (averages for 15 tests on cases 25 to 33)	17.1	20.7	4.5

He was frequently forced to drop out of drill. Physical examination was not remarkable. The pain was reproduced in typical fashion by each of three rebreathing tests. Since he was one of the earliest cases, the A and B electrocardiographic series were incomplete. However, the fourth lead was taken in test C. All deviations were well within normal limits, and the diagnosis of neurocirculatory asthenia seemed far more justified. The soldier was reassured and returned to duty. Subsequent check-up showed that he had done well.

Conclusions

1. The rebreathing test herein described provides an effective means of inducing sufficient anoxia to reproduce cardiac symptoms and at the same time to cause significant electrocardiographic changes, if coronary insufficiency is present.

2. The spirometric measurements of the patients with heart disease closely resemble those of the normal controls. Thus, the angles of ascent of the respiratory tracings average about 17 degrees; the last minute volume of respiration averages 20 liters; and symptoms may be expected to appear within five minutes.

3. Electrocardiographically, the results of the tests among the group with coronary heart disease stand in contrast to those found in the rest of the series. By and large, RS–T segment and T–wave changes are the more marked in the coronary cases, averaging three times greater, for instance, in T_1. However, the one distinguishing feature between these groups is the excursion of T–waves across the isoelectric line. The phenomenon occurred to a minor degree among a few of the patients without coronary disease, but proved conspicuous in the coronary group. This sign in lead IV is considered pathognomonic of coronary insufficiency.

4. Because this test is safe, simple, and dependent upon no elaborate apparatus, it furnishes a practical method which can be employed in the physician's office.

CLINICAL DAY TO BE HELD AT VETERANS ADMINISTRATION HOSPITAL, WOOD

A clinical day, conducted by the residents in medicine and sponsored by the Veterans Administration Hospital, Wood, and the Dean's Committee of Marquette University School of Medicine will be held at the Veterans Administration Hospital on July 1. All physicians are invited to attend. Dr. Maurice Hardgrove, senior consultant in internal medicine, is chairman of the morning session, and Dr. Mark W. Garry, chief of the medical service, will preside over the afternoon program. Following the scientific presentations, a play, "The Imaginary Invalid" by Moliere, will be presented by the residents in internal medicine in the hospital theater at 8 o'clock in the evening.

The following scientific program has been arranged:

A. M.

9:30 Opening remarks—John S. Hirschboeck, M. D., Dean, Marquette University School of Medicine; Fred W. Madison, M. D., Dean's Committee, Internal Medicine
9:45 "A Comparison of Methods of Circulation Times"—William H. Drischler, M. D.
10:00 "Dicoumarol in Myocardial Infarction"—Thomas H. Davidson, M. D.
10:15 "Ether and Procaine in Treatment of Peripheral Vascular Diseases"—Bertram H. Dessel, M. D.
10:30 "Tetraethyl Ammonium Ion Studies"—Herbert M. Snodgrass, M. D.
10:45 Rest period
11:00 "Dibenamine"—Daniel J. Mendelson, M. D. (Eugene F. Brandt, M. D.)
11:15 "Experience With Gout at Wood Hospital"—George N. Spencer, M. D.
11:30 "Diagnostic Significance of Radiating Pain in Rheumatic Disease"—Robert L. Paver, M. D.

A. M.

11:45 "Medical Pain Relief"—Matthew W. Monroe, M. D.
12:00 noon Luncheon

P. M.

2:00 "Evaluation of Serum Albumin"—George L. Baum, M. D.
2:15 "Blood Acetone Estimation"—Aloys W. Hickey, M. D.
2:30 "Observations on the Insulin Tolerance Test"—Julius M. Meyer, M. D.
2:45 "Benzoyl Glycuronic Liver Function Test"—Karl A. Liefert, M. D.
3:00 Rest period
3:15 "Renal Function in Relation to the Adrenal Gland Cortex"—Willard H. Spankus, M. D.
3:30 "Tropical Eosinophilia"—Jack J. Levin, M. D.
3:45 "Experience With Malaria at Wood Hospital"—Edwin C. Welsh, M. D.
8:00 "The Imaginary Invalid" by Moliere—Residents in Internal Medicine

Practical Aspects of Diagnosing Brain Tumors

By R. H. QUADE, M. D.
Neenah

R. H. QUADE

Doctor Quade received a bachelor of science degree from the University of Wisconsin in 1927 and his medical degree from Northwestern University Medical School in 1930. After serving a residency at the Mayo Clinic, in 1938 he received a master of science degree in neurosurgery at the University of Minnesota Medical School. He is a Fellow of the American College of Surgeons and is certified by the American Board of Neurological Surgery.

ADVANCES in psychiatry, psychosomatic medicine, neurology, and neurosurgery have in the past decade made a definite impact upon the whole field of medicine. Better than 50 per cent of a physician's daily work is directly or indirectly concerned with disturbances of the nervous system, either functional or organic or both. The recognition of these factors is mandatory to good medical practice.

In the past, neurology and psychiatry have operated behind a curtain of difficult and obscure terminology and technics, these fields being segregated in the stratosphere insofar as the general practitioner was concerned.

Recent trends have helped to bring psychiatry and neurology and their technics directly to the general physician, where they belong. This discussion is in the spirit of this trend.

Neurologic Diagnosis

The technic of neurologic diagnosis differs from general medical diagnosis. Medical diagnosis tends to be positive in its character. For example, a fibroid tumor of the uterus involves menstrual disturbance associated with a palpable mass. In neurologic diagnosis, the disease is not manifested by signs of itself but by its effect on the functioning of the nervous system. A destructive lesion causes a loss of function or sets up a release mechanism. An irritative lesion produces reactive symptoms, in the form of sensory or motor irritation syndromes.

The important consideration is that any specific change in function is not significant of a special disease. Numerous kinds of lesions will produce the same symptom complex if they happen to involve the same nervous system structure. In the brain similar clinical pictures are produced by such diverse causes as tumors, vascular disease, toxic degenerative states, trauma, and the end results of inflammatory disease.

In neurologic diagnosis four questions should be answered:

1. Is a lesion present? This implies a differentiation of a functional or organic cause for the patient's complaints. This not infrequently is the most difficult of the four questions.

2. Where is the lesion? This is determined by the neurologic examination, which localizes the lesion as to the level or structures of the nervous system involved.

3. What is the lesion? Is it inflammatory, neoplastic, toxic, degenerative, vascular, congenital, or traumatic? The answer is based on the history and course of the affliction, the association with other systemic disturbances, hereditary factors, etc.

4. What causes the lesion? The answer depends on a complete general examination. A brain tumor may be a primary glioma or a metastatic cancer.

Upon answering these four questions correctly, a specific diagnosis can be made. Actually of most importance is the recognition of the presence of neurologic disease. Of next importance is localization of the process. Of final importance is identification of the process.

Neurologic diagnosis has three dimensions. The first dimension is that of the presenting symptoms. The second dimension is the results of the clinical examination. These two dimensions constitute a plane which will localize a lesion in the nervous system but will not give information as to the character of the lesion. The character of the lesion can only be inferred by a third dimension—that of time—which gives depth to the picture. The main factor in the differential diagnosis of brain lesions resides in complete evaluation of this dimension of time. Technical laboratory procedures will not answer this question. The history and course of an affliction are in many cases the final and only source through which identification can be made. If the history and present examination are inconclusive, then, again, the third dimension of time must be invoked in the form of observation in the future for evidence of progression in a case of suspected brain tumor. Improvement of the clinical picture would identify it in some other diagnostic category than brain tumor.

Character of Brain Tumors

As to brain tumors, their existence therefore has to be inferred. The accepted cardinal symptoms of brain tumors, *i.e.*, headache, vomiting, and visual changes, are actually the result of increased intracranial pressure. Such pressure may result from other causes than brain tumor.

In addition to the syndrome of increased intracranial pressure, *i.e.*, headache, vomiting, and visual changes, additional symptoms of epilepsy, drowsy and comatose states, intellectual impairment, personality changes, monoplegic, hemiplegic, and paraplegic states, and cumulative involvements of cranial nerves are common to brain tumors. A group, or cluster, of progressively developing neurologic signs is characteristic of brain tumor.

Headache as a Symptom

Headache is the most common symptom of brain tumor. However, a very large tumor may be present without headache, particularly where its location is such as not to obstruct the circulation of the cerebrospinal fluid. Increased intracranial pressure means obstruction to the flow of the cerebrospinal fluid. Brain tumor headaches are also caused by tension phenomena as to dural structures and blood vessels. Associated tenderness of the scalp over the lesion may be present.

About half of brain tumor headaches are localized; about half are diffuse. They are usually described as deep and expanding. They frequently occur early in the morning and are not continuous.

Psychogenic headaches are more superficial, more radiating, more constant, and more unremitting. They are stabbing or boring. They are confined to the top or back of the head. They are frequently described as a constricting band. Migraine is another category.

Experience is a great teacher. For this reason case histories are invaluable in illustrating clinical lessons.

A group of cases referred as brain tumors is briefly summarized.

The following case illustrates diagnostic pitfalls when headache occurs without corroborative neurologic evidence indicating a definite brain lesion. The first question of whether a lesion is present, *i.e.*, the differential diagnosis of organic from functional, may be exceedingly difficult.

A woman, aged 26, obese, with secondary anemia and hypothyroid appearance, gave a long history of emotional instability and a present difficulty in her personal life situation. She presented a recent diffuse type of headache, without objective neurologic findings on complete hospital examination. Psychosomatic concepts appeared to account for her complaint, along with probable endocrine disturbance. Three weeks later choking of the optic disks became apparent and ventriculogram and craniotomy verified an inoperable, large, infiltrating malignant glioma.

This is a typical history in a case of this malignant type of brain lesion which occurs just often enough to make headache a diagnostic quandary. Obviously, air studies are not to be done in every case of headache. Even if air studies had been done three weeks earlier and early correct diagnosis made, the fatal course would not have been changed. The lesson to be learned is that a psychosomatic diagnosis should be guarded and not considered final until proved by time.

Subdural Hematoma

A man, aged 24, presented symptoms of recurrent occipital headaches for three to four months. He had been receiving sinus treatments. With recent severe headaches there had been vomiting with relief of headache. Neurologic and general examination was negative. There were no clinical signs of increased intracranial pressure. Under observation in the hospital, early choking of the right optic disk developed. Ventriculogram was indicated. The right ventricular opening disclosed a large, liquid, subdural hematoma, which was drained. The left side was negative. Uneventful recovery occurred. The history revealed that he had bumped his head on a pipe while walking in a basement a few days previous to the onset of his headaches.

Subdural hematoma is an ubiquitous lesion which may be absent when suspected and may pleasantly surprise the surgeon when he anticipates a neoplasm. One must always be aware of its possibility and suspect it in any case with progressive development of intracranial symptoms following particularly relatively slight head traumas. The resultant syndrome is that of an expanding intracranial lesion which is indistinguishable neurologically from tumor. The history holds the only clue.

Cerebral Aneurysm

A man, aged 43, had been subject to severe headaches. While lifting a crate on a truck he had sudden severe pain in the right forehead and face followed by agonizing diffuse headache. Blood was present in the spinal fluid. Ocular paralysis was present. In a few days, choking of the right optic disk with hemorrhages was evident. The left optic disk remained essentially normal. The diagnosis was ruptured aneurysm involving the anterior circle of Willis on the right side. The significant diagnostic feature was the history of pain in the face, which results from irritation of the trigeminal nerve by blood spilling from the aneurysm. Recovery occurred from this attack. A guarded prognosis was given; later a fatal rupture occurred, and autopsy verified the lesion.

Cerebral aneurysms are not an uncommon lesion and must be suspected in severe headache syndromes. Neurosurgery is now making definite advances as to treatment of this condition.

Inflammatory Lesions

A woman, aged 28, complained of severe expanding type of headache for six weeks. The only clinical finding was 2 D bilateral choked disks. Ventriculogram was negative. The inferred diagnosis was low grade inflammatory process, cause unknown, and conservative treatment was instituted. Complete recovery has occurred over a four year period. This again emphasizes the nonspecific etiologic character of neurologic syndromes.

Vascular Lesions

A man, aged 50, while using air hammer, complained of severe headache followed by semistuporous, agitated state without choked disk or localizing signs. Spotty skin lesions were present over the tibia. Muscle biopsy verified periarteritis nodosum as the pathologic lesion.

Emphasis must be made as to the high incidence of vascular lesions producing neurologic disturbances. Cerebral thrombosis and embolism are commonly associated with toxic, inflammatory, and degenerative states. The differential diagnosis rests on evaluation of the time factor. If there is repetition of the same clinical syndrome, indicating one localization of pathology, then slow-growing tumor or aneurysm is responsible. Variability of clinical syndromes indicates a vascular cause.

Vomiting as a Symptom

As to the symptom of vomiting, when associated with brain tumor, it usually occurs at the peak of a headache and is usually followed by relief of the headache. Nausea may or may not be associated. Projectile vomiting suggests increased intracranial pressure.

In a woman of 48 years, asthenic, nervous for many years, who had just gone through the ordeal of moving her household, more or less continuous vomiting developed, and she was unable to keep down any food for three weeks. The condition has been diagnosed anorexia nervosa. Neurologic examination was objectively negative. The only significant finding was that changing position in bed would induce vomiting. This suggested a medullary syndrome, but there were no other brain stem signs. Under observation in two weeks there was evidence of a progressive lesion. Ventriculogram revealed a subtentorial lesion. Cerebellar craniotomy verified a walnut-sized gliomatous tumor involving the anterior portion of the vermis.

This case again verifies the ubiquity of brain tumors and illustrates the ease with which a psychosomatic diagnosis can incorrectly be made. The important factor again is the value of the use of time in establishing a diagnosis.

Visual Changes

The next important symptom as to brain tumor is that of visual changes. The ophthalmoscope is more important in diagnosing lesions of the brain than the stethoscope in diagnosing lesions of the chest. Every physician can and should use an ophthalmoscope in his routine physical examination, particularly in the cases of headache. A choked disk is a very evident lesion.

Visual acuity is readily tested with a simple Snellen chart.

Visual fields can readily be grossly checked by the confrontation method, and a defect in the fields suspected when a patient states that he bumps into things to the right or left, etc.

The evidence of visual changes is of definite significance in pituitary tumors, which tumors are particularly amenable to surgical treatment. It is an unnecessary tragedy to have blindness the end result of neglect of a pituitary tumor.

Convulsions

As to convulsions, they represent a cataclysmic disturbance in brain wave pattern—equivalent to an electrical storm over the cortex of the brain which arises from a center of disturbance a focus of irritation, or a trigger zone. The location of this focus of irritation determines the convulsive pattern.

Convulsive patterns have great diagnostic significance, and it is essential to get an accurate description of the fit, including all premonitory states, aura if present, the exact character of the fit, head turning, eye turning, tonic and clonic character, and the postepileptic state. Jacksonian attacks, that is, attacks limited to one side of the body or to an arm or leg, or beginning there, localize the focus to the opposite motor cortex. A sensory aura localizes to the corresponding sensory cortex. A tonic fit localizes the lesion to the lower levels of the brain. Peculiar or abnormal behavior indicates psychomotor type of attack, indicating the frontal lobes. Flashing lights indicate the occipital lobes. Optical illusions of forms indicate closer approximation to the temporal lobe. Peculiar unpleasant sensation of taste and smell with smacking of lips constitutes the so-called uncinate fit and is significant of temporal lobe lesions. Time does not permit further evaluation.

Convulsions are also indiscriminate as to etiology; practically all pathologic factors affecting the brain are able to produce this type of symptom. In general, with convulsions beginning after adolescence it is necessary to rule out brain tumor before attributing this symptom to other causes. Air encephalograms are the final answer to this question.

Even in children one can not just dismiss the case as another case of epilepsy.

A boy of 14 had a history of three to four years of grand mal attacks with an aura involving the left hand. Neurologic examination was negative. The child was improved under the usual anticonvulsants. Six months later the attacks became more frequent and there was evidence of loss of finer motor functions of the left hand, particularly for hours or days after an attack. Air encephalogram revealed a space-occupying lesion in the right frontoparietal region. Craniotomy verified an egg-sized globular meningioma, which was removed.

A woman, aged 22, presented history of convulsions since childhood. She had seen many physicians and was told she was a chronic epileptic. Her convulsions were generalized and without aura, but during the preceding year they would leave her with temporary weakness on the right side of the body. Encephalograms revealed a left parietal space-occupying lesion. A dermoid tumor was removed.

A woman, aged 53, recently treated for neisserian peritonitis was referred with a history of years of nervous instability. While sitting at the radio, she had heard a report that a ship on which her son was sailing had been sunk by enemy action. She immediately had an attack in which she smelled burning flesh. Following this she had repeated attacks of smelling burning flesh associated with marked flushing and feeling of heat through her body. Neurologic examination was negative. A diagnosis of neurosis was made in spite of a history suggesting uncinate fits indicative of a temporal lobe tumor. Four months later the patient came to the hospital by ambulance, hemiplegic and moribund. Postmortem examination verified a huge, malignant glioma of the temporal lobe.

This is a good example for not relying on circumstantial evidence in making a functional diag-

nosis. The psychosomatic approach is of real value in understanding human ailments, but it is easy to consider all bizarre syndromes as functional and forget that organic disease must be positively ruled out or evaluated before interpreting the psychic factors.

Personality Changes

As to personality changes, this may be the only indication over a long period of time of a brain tumor. Such changes are significant of frontal lobe pathology and are characteristic of frontal lobe tumors.

A man, aged 48, was seen in a state of mental confusion with hemiplegia, hemianesthesia, some aphasia, and hemianopsia, all of a few weeks' duration. Surgery verified a huge glioma of the left frontoparietotemporal lobes. Of particular interest was the history that over a two year period a previously productive stable citizen suffered a series of job demotions, divorce, family disruption, and an orgy of wine, women, and song.

Cranial Nerve Syndrome

As to the cranial nerve, the cerebellopontine angle tumors are important. Neurofibromata of the eighth nerve are relatively common and have a specific diagnostic picture. They begin with symptoms of tinnitus followed by deafness and then progressive involvement of the fifth, sixth, seventh, ninth, and tenth nerves along with brain stem and cerebellar signs. X-rays of the skull specifically show erosion of the internal acoustic meati. This benign lesion when diagnosed reasonably early is well relieved by surgery. This condition should be ruled out in every case of progressive deafness.

Brain Lesions in Children

Brain tumors of children constitute a separate category in that they are mainly cerebellar. They are usually diagnosed as gastrointestinal upsets or allergies inasmuch as the presenting symptoms are headache, vomiting, and gastrointestinal upsets. The wary physician will be on the outlook for disturbances in gait and for choked disks in these cases.

There are also other causes for choked disks in children than brain tumor. Lead poisoning must always be considered. Children eat paint from toys or walls. In addition, the infectious diseases are prone to cause arachnoiditis or meningoencephalitis, with resultant increased intracranial pressure syndrome. Conservative treatment in the form of dehydration and use of antibiotics often results in recovery. For arachnoiditis, surgery may be necessary. Careful daily observation of the fundi is essential. Progression makes surgery mandatory. Regression verifies the right to continue conservative treatment. Vision and life are in the balance.

Granulomas

A word must be said as to the granulomas; particularly syphilis and tuberculosis must be ruled out in all cases.

Laboratory Procedures

Metastatic cancer must always be considered and routine chest x-rays done to rule out metastases.

As to laboratory procedures, x-rays of the skull will give supportive evidence of brain tumor in about 50 per cent of the cases. X-rays of the skull are mandatory in the differential diagnosis of any suspected intracranial lesion.

Encephalograms and ventriculograms constitute the final umpire when a diagnosis is in dispute. There is some risk to these procedures, and they are therefore contraindicated, unless the question of ruling out brain tumor is necessitated by the character or progression of the specific case.

Electroencephalograms are an important aid, but, again, are nonspecific as to indicating the specific pathology.

Summary

In conclusion, the diagnosis of brain tumor is by process of inference. Clinical findings as to the central nervous system are nonspecific in character, and the differential diagnosis involves the entire gamut of general medical diagnosis. The approach must be practical. Early diagnosis is essential and is a primary factor in good surgical results. The suspicion of brain tumor involves careful evaulation clinically, with particular stress on the time factor in the form of a careful chronologic history, and if necessary, the enlisting of time in the form of further observation to prove the character of the central nervous system lesion. Surgical interference is justified only when complete evaluation of a case verifies its necessity or advisability.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES POSTGRADUATE COURSES IN POLIO

The Division of Graduate Medical Education at the University of Wisconsin Medical School has announced that it will present two courses in poliomyelitis this summer. The first, from June 28 to July 3, is planned for physicians and will cover both academic and practical aspects in the diagnosis and treatment of the disease. Immediately following the conclusion of this course, a course for graduate nurses will be given by the nursing staff at the State of Wisconsin General Hospital and the Wisconsin Orthopedic Hospital for Children. Extending from July 6 through July 9, it will cover the most current nursing technics and will be of particular value to supervising nurses.

Further details may be obtained from Llewellyn R. Cole, M. D., Coordinator of Graduate Medical Education, University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

Objectives in the Management of Children With Diabetes Mellitus*

By ROBERT L. JACKSON, M. D.
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R. L. JACKSON

Doctor Jackson is associate professor in the department of pediatrics at the State University of Iowa College of Medicine, Iowa City. He received his education at the University of Notre Dame and the University of Michigan Medical School, receiving his M. D. degree from the latter in 1934. Certified by the American Board of Pediatrics in 1940, he has contributed extensively to the literature on pediatrics.

TREATMENT in the Children's Hospital at the State University of Iowa College of Medicine has been based on the premises that the diabetic child has normal propensities for health as long as his diabetes is well controlled and that therapy should be based on the maintenance of normal physiologic conditions as far as possible.

Diabetes mellitus in the young patient is so different from diabetes mellitus in the middle-aged or elderly patient that it requires special consideration from a therapeutic standpoint. The majority of children and young adults are undernourished when the disease is first discovered, and the onset is relatively sudden. The majority of the older patients are obese when the disease is first discovered, and the onset is frequently insidious. The disease in the child, as contrasted to the disease in the adult, is more severe. The nutritional requirements for the child are relatively greater and constantly changing, and infections are more frequent and severe. Exercise is much more erratic, and the emotional pattern is less stable in adolescence. On the basis of these differences, it is safer from the standpoint of practical therapeutics to consider diabetes of the young patient as distinct from diabetes of the middle-aged or elderly patient.

At present, the three controversial questions regarding the treatment of young patients with diabetes mellitus are:

1. What constitutes an adequate level of control for juvenile patients with diabetes mellitus?
2. Which type of insulin should be employed in order to attain this level of control, a slowly or a rapidly acting insulin or a combination of the two?
3. Is the accelerated vascular damage that develops in diabetic patients an associated phenomenon of the disease, or does it reflect inadequacies in the level of control?

Regimen of Therapy For Complete Control of the Disease

If the child with diabetes mellitus is treated early and adequately, complete control of the disease can be maintained.[1] The longer the disease is incompletely controlled, the more difficult it will be to attain and maintain complete control.

The regimen employed by us to attain complete control of the disease until recently has consisted of the giving of a nutritionally adequate diet divided into three equicaloric meals and the administration of amorphous regular insulin. The insulin was given one-half hour before each meal and once during the night, usually at 1:00 a.m. The distribution of the day's dose among the four injections was approximately 35, 22, 28, and 15 per cent respectively. Although this regimen may seem difficult, because it involves the administration of four injections of regular insulin daily, it has been our experience that the families have been so well pleased with the child's response that they have been very willing to use this plan.

Many clinicians have raised the question of the practicability of our regimen of therapy, which aims to keep the diabetic child free from insulin reactions and free from glycosuria while receiving a normal diet even if this requires frequent injections of insulin. We realize that the advantages of a higher level of control have not been indisputably demonstrated. The most notable apparent effect of prolonged hyperglycemia is evidenced by the difference in response between patients who recently have become diabetic and those who have remained mildly glycosuric for some time before complete control is attempted. The latter patients have a much narrower zone of stability and are definitely more difficult to control than patients whose disease has been well controlled soon after the onset of the disease. It is uncommon for any of our well controlled patients to have to be readmitted to the hospital even during relatively severe intercurrent infections. The use of more frequent small injections of insulin allows a greater degree of safety and produces a feeling of security on the part of the mother that she can control the situation. It is our impression that it is a tendency of others to place too much emphasis on the desirability of reducing the number of injec-

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tions of insulin. Parents' willingness to make some added effort in order to give their children every opportunity to conserve their health may be underestimated. Our clinical experience has been that it is not only possible but practical to maintain this high level of control for the child who comes from an ordinarily well adjusted home. Although the regimen is rigid at first, the child learns a great deal about his disease and is able gradually to simplify his own care. These children have such a wide range of safety that they frequently remark that they cannot believe there is anything wrong with them. We have felt that these children are making a remarkably good psychologic and sociologic adjustment.

At the present time there is almost universal agreement that the diet for the child with diabetes mellitus should be essentially the same as for normal children. In 1942 a study was made of the type of diet with respect to the relative amounts of fat and carbohydrates best suited for juvenile patients with diabetes mellitus.[2] It was concluded that in the treatment of the child with stabilized diabetes mellitus, emphasis should be directed toward having nutritionally complete diets, similar to the normal diet and quantitative primarily from the standpoint of calories. If these criteria are satisfied, special attention need not be given the fatty acid-dextrose ratio of the individual meals and probably not of the entire diet.

We have only recently found it possible to use the combination of a rapidly acting insulin and a slowly acting insulin without having to sacrifice the level of control of the disease. Our results with protamine zinc insulin on the whole have been very unsatisfactory.[3] We have attributed these unsatisfactory results to the duration of action of the protamine zinc insulin, which may exceed twenty-four hours and which consequently may have some cumulative action from day to day. In order to use protamine zinc insulin for the treatment of a juvenile diabetic patient, it is necessary for one to be satisfied with a level of control which permits at least minimal glycosuria as a safeguard against shock. We have not been willing to make this compromise except for the occasional uncooperative patient, whose dietary indiscretions and social habits make a good level of control impossible in any case.

Globin insulin with zinc now is used in place of the evening and night doses of regular insulin (43 per cent of the total) and given one hour before the evening meal. Half the milk (146 calories) is taken from this meal and given three hours later.

A detailed hospital and outpatient study was done in order to validate this change of regimen and show that complete regulation can be maintained.[4] The outpatient study clearly demonstrated that it is possible and practical to keep diabetic children aglycosuric, except for very occasional traces of sugar in the urine and free from clinically significant insulin reactions.

The records of the home regulation of 23 patients observed a total of 1,062 patient-weeks (20.4 patient-years) were carefully studied. The over-all control of these diabetic subjects was excellent or good for 19 and fair for 4 children. The periods of observation were during weeks when the patients were free from infection. During the 1,062 patient-weeks there were 42 insulin reactions, or about 1 reaction every six months. Eighty-three per cent were mild reactions.

Normal Growth For Children With Diabetes

Normal growth is an objective of our diabetic regimen for children. Numerous growth studies of children with diabetes mellitus have been reported. These studies reveal that compensated diabetes is compatible with normal growth but that many children with the disease do not grow normally. The importance of an adequate diet has been established for the diabetic as well as the nondiabetic child. Recently we studied the growth of diabetic children under our observation for at least two years.[5] The records of 120 juvenile diabetic patients in our clinic were reviewed to determine the relationship between the growth of children with diabetes mellitus and the level of control of the disease.

The interpretation of the varying levels of diabetic control is given in this tabulation:

Very good to excellent: Urine specimens are free from sugar except for occasional traces; very occasional mild insulin shocks.

Good: Urine specimens free from sugar except for occasional traces; occasional mild insulin shocks.

Fair to good: More than one-half of the urine specimens free from sugar but minimal glycosuria in remaining specimens; occasional insulin shocks of varying degree.

Fair: Less than one-half of the urine specimens free from sugar and varying amounts of sugar in remaining specimens; occasional insulin shocks of varying degree.

Poor: Urine specimens contain varying amounts of sugar continuously; occasional insulin shocks.

As a group there was a much stronger tendency for the growth of the children to be normal or accelerated than to be retarded.

Since growth in height of the normal child is more predictable during childhood than during prepuberty and puberty, we studied growth curves of a group of 53 diabetic children who had height observations at least two years before 10 years of age. The differences in growth of these children grouped according to the level of diabetic control were statistically significant.

This study demonstrated the importance of early and complete management in order to prevent retardation of growth and development. For children already stunted from improper care, the importance of complete management is also demonstrated as a means of ameliorating retardation of growth and development.

Avoidance or Postponement of Degenerative Changes

To determine whether the vascular damage is a manifestation of the disease itself or a complication resulting from noncontrol, it is necessary that a large group of juvenile diabetic subjects who have had their disease well controlled be observed for long periods. We have already defined our criteria for various levels of control. Wagner, White, and Bogan[6] consider a child in very good diabetic control if he is excreting no more than 10 per cent of the ingested carbohydrate, in good diabetic control if he is excreting no more than 20 per cent of the ingested carbohydrate, and in poor diabetic control if he is excreting more than 20 per cent of the ingested carbohydrate. We are of the opinion that any child excreting as much as 10 per cent of his ingested carbohydrate approximating poor diabetic control. The very good control group, as defined by these authors, would include the first four groups by our standards of control (very good to excellent, good, fair to good, and fair). The good control group by their standards would comprise, for the most part, our poor control group.

Dolger[7] in August of last year reviewed the literature and reported a high incidence of vascular damage in a group of 200 diabetic subjects, 55 of whom were juvenile patients. Not one escaped retinal hemorrhage, regardless of age of onset, severity of diabetes or type of treatment used. He stated that "20 young diabetic patients satisfied all orthodox criteria for excellent diabetic control, namely, adherence to moderate carbohydrate, low fat diets, and exhibition of little or no glycosuria. Within a range of six to twenty-two years' duration, retinal hemorrhages were noted in all, with an average duration of diabetes of thirteen years when the earliest lesions were observed. By the time retinopathy had developed 50 per cent of patients presented definite hypertension and 30 per cent albuminuria. The first patient to receive insulin at Mount Sinai Hospital was a girl nine years of age. The control of her disease has always been considered perfect. For the past ten years she has never presented a single instance of glycosuria on a diet of carbohydrate 150 Gm., protein 80 Gm., and fat 80 Gm., with a fixed dose of 60 units of protamine zinc insulin. Twenty-two years after onset of diabetes numerous retinal hemorrhages were observed along with albuminuria and a blood pressure of 150 systolic and 100 diastolic."

We have never been able to approximate aglycosuria using the described plan of therapy employing one dose of protamine insulin. Many children come to our clinic who have been on such a regimen and with a history of freedom from sugar in the urine. Usually only the early morning urine specimen had been tested. Their twenty-four hour urine specimens always have shown moderate amounts of glucose.

In 1941 we reviewed the incidence of degenerative changes in 69 juvenile diabetic patients.[8] Of these 69, 60 had been recognizedly diabetic for five years or longer, and 42 of them had had the disease for not less than ten years. Fifty of the group had been under intermittent observation in our clinic for five years or longer and 32 of them for not less than ten years. The remaining 19 had been observed over periods varying from single hospital admissions to periods approximating five years. The same principles of diabetic control were prescribed for all subjects, but the manner and degree of cooperation differed widely within the group.

Two methods of appraisal of the vascular system were available from the routine of examination. The first of these, roentgenograms of the soft tissues of the wrists or ankles, revealed no evidence of arteriosclerosis in any subject. The other, the ophthalmoscopic examination, offered evidence of arterial disease in only 1 subject. This was a girl who was 20 years old when first seen by us. She had had diabetes for eighteen years of her life and throughout that time had never been adequately controlled. Her physical abnormalities included dwarfism, infantilism, albuminuric retinitis with bilateral choked disks, retinal hemorrhages, hypertension, uremia, and posterior subcapsular lens opacities.

A second subject who returned to the hospital after several years of noncontrol had rather similar findings, including dwarfism, enlarged liver, infantilism, retinal hemorrhages and edema of the right nerve head (choked disk). After six months of fairly rigorous control, examination revealed the disk had returned to a normal appearance, the hemorrhages had been reabsorbed, and liver enlargement had subsided. Even though her subsequent control left much to be desired, she went on to maturation, married, and was delivered of a normal baby.

Six subjects showed retinal hemorrhages, coincident with variable periods of poor control. In some instances these periods were of only a few months' duration. In 1 subject they were recurrent. In general they tended to subside and to disappear with the resumption of suitable control.

Clinically demonstrable diabetic cataracts were observed in 6 children. In each instance they were noted at the initial examination in our clinic. All were subjects in the second decade of life, in each of whom clinical diabetes had developed not more than two years prior to the appearance of the cataracts, and had remained in a state of noncontrolled diabetes during that time.

In addition to these obvious opacities of the lens, posterior subcapsular opacities of minor degree were discovered in almost one-third of the members of the series. These lesions were detectable only through the use of the slit lamp and the biomicroscope and would not have been discovered with any other form of examination. In each instance the appearance was coincident with a period of noncontrol of the diabetes or immediately after it. They are the precursors of the clinically apparent opacity

and will terminate as such unless their course is checked. In each instance, however, the announcement of their presence to the patient and his parents and an explanation as to their significance and course led to the resumption of desirable levels of control. Thereafter, there was no further increase in lens opacities in these subjects, and their eyes remained free from functional handicap. Similar lesions have not been found in the eyes of those children whose management has been maintained at a satisfactory level.

The level of control of our diabetic patients has improved as understanding of insulin activity and other factors in the control of the disease has grown. For example, we have learned how to compensate for variations in physical activity and are publishing a study of these findings. With six more years of additional information we are again reviewing our records to evaluate the relationship between diabetic control and the progression of degenerative changes. It will be necessary to continue to observe these well controlled patients for a longer period of time to know definitely the relation of the progress of degenerative changes to the disease. It is our clinical impression that a high level of control will delay or prevent the development of degenerative vascular changes. Dwarfism also was considered a phenomenon of the disease, but well controlled groups of patients have demonstrated the error of this concept.

Summary

Diabetes mellitus in the young patient is different from diabetes mellitus in the middle-aged or elderly patient and requires special consideration from a therapeutic standpoint. It is possible and practical to maintain complete control of the disease if the child is treated early and adequately. A high level of control prevents retardation of growth and development and possibly delays or prevents the development of degenerative changes.

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Protein and Amino Acid Utilization*

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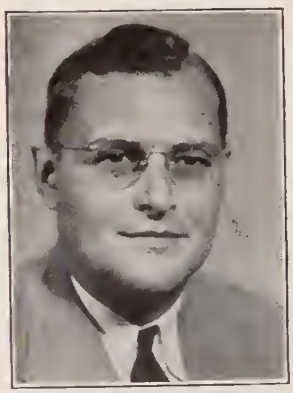

O. V. HIBMA

A native of Madison, Doctor Hibma received his medical education at the University of Wisconsin Medical School, graduating in 1939. Following internship at Cincinnati General Hospital, he served a three year surgical residency at the State of Wisconsin General Hospital. He was instructor in surgery at the University of Wisconsin Medical School until 1946, when he entered the private practice of surgery in Madison. He is a diplomate of the American Board of Surgery.

THE patient who can eat and drink offers us no problem as far as nutrition is concerned. However, as soon as food and fluid cannot be taken or can be taken only in limited quantities, we are immediately faced with the problem of furnishing vital food substances to these patients in a form which can be tolerated, by routes other than the oral route of administration. Fluid, calories, and minerals have long been given by the parenteral route, and this method has saved untold thousands of lives. As the vitamins have been identified and synthesized, their parenteral administration has been possible, since the dosage has been relatively small. However, the problem of protein replacement has not been that simple.

The protein problem at first was not recognized as a real problem in the nutritional balance of these patients. It was thought for a long time that the vast stores of protein in the muscle masses of the body served as the source of proteins when none

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were taken orally, much the same as we know that the fat deposits are utilized for part of the fuel needs of the body when insufficient calories are ingested. We now know that this is not the case. We now know that the reason for the gradual decline in the plasma proteins, the method we have of studying body proteins, was not due to the fact that the muscle masses were acting as a protein reserve, but that all proteins, particularly those from vital organs, as the liver, intestinal tract, and the kidneys, were being depleted more or less at a regular rate. Therefore, large amounts of protein have to be lost first before there is even a small reflection in plasma protein levels, since the plasma protein represents only approximately one-thirtieth of the total proteins of the body.

Excess fat and carbohydrate which are taken into the body are stored as fat and glycogen. In striking contrast is the fact that amino acids are utilized immediately for their normal function or are catabolized and burned as fuel. There is little evidence for the presence of any protein, including that in the muscle masses, which has the function of the storing of amino acids. It is true, however, that an animal in a healthy state does contain more protein than one deprived of amino acids necessary for adequate nutrition.

On an adequate nutritional diet, the liver, alimentary tract, and kidneys do increase in size and weight faster than do the other organs, and conversely these three organs decrease in size and weight more rapidly than do the other organs during periods of starvation; experiments having shown that on a seven day starvation diet the liver lost 40 per cent of its protein, the alimentary tract 28 per cent, and the kidney 20 per cent, as compared to muscle, which had lost only 5 per cent of its protein. But this is not a case of depots for protein storage, since this lost protein represents vital protein as far as these organs are concerned. Evidence is particularly abundant showing that these protein-depleted livers are particularly susceptible to injury by a great variety of toxic agents. Thus we now must recognize that protein depletion is a real problem, which begins as soon as the patient can no longer eat or drink, or does so in limited quantities.

When parenteral administration is necessary, we must next consider in what forms the protein can be for this administration. Proteins thus can be administered in two forms, namely, whole protein or, secondly, in the form of its basic components, amino acids. The history of the attempts which were made in administering whole proteins makes very long and interesting reading. These early attempts failed primarily because whole proteins are antigens and caused severe and often fatal anaphylactic reactions, which were then not recognized as such but which reactions were recognized as the real danger in administering whole proteins by the parenteral route. The only whole protein which we have been able to administer safely is that of human plasma protein. The other form of protein which can be administered parenterally is that of an appropriate solution of amino acids, which are the basic constituents of all proteins. These were first administered in human beings by Robert Elman in 1939, and since then much clinical and experimental work has been done in their study.

Physiology of Proteins

In order to discuss the use and value of the amino acids in protein metabolism, I would like to give a brief review of the physiology of proteins in the body. Proteins are ingested as such, and are digested in the upper small intestine, finally, through the action of trypsin. The end products of digestion are peptides and amino acids. In these forms they are absorbed into the blood stream and carried to the liver. Here, depending upon the needs of the body, they are disposed of in one of several ways: 1. They may remain in the blood stream as original amino acids. 2. The amino acids may be linked to one another to form new proteins which are needed by the body. 3. If there is a need on the part of the body for a particular amino acid, the liver may synthesize it from one or more of the available amino acids. The liver can not synthesize all the known amino acids but can synthesize approximately 50 per cent of them. The so-called essential amino acids cannot be thus synthesized. 4. All the remaining amino acids which are not required for body building or tissue repair or which cannot be utilized at that particular time are converted by the liver into carbohydrates by a process of deaminization. In this process the NH_2 radical is split from the amino acid and combines with readily available carbon dioxide to form urea. The blood and tissue urea is kept at more or less of a constant level, and any excess urea formed is immediately excreted in the urine. Thus, this process of deaminization and urea formation controls any overload on the system.

On the other hand, a marked decrease or absence of protein intake results in a near cessation of urea formation. Nevertheless, the body needs some protein, since there is a continual breakdown of some of the tissue proteins from wear and tear (catabolism). Thus if none are supplied, you can readily see that there will be a constant and continual loss of tissue and blood proteins.

Indications for Use of Amino Acids

If an individual can ingest orally, digest, and absorb proteins, the oral route of administration of protein still is the best. The prime indication for the parenteral administration of amino acids is in the individual who cannot take foods orally. Here we have the opportunity to present proteins in a form which is not foreign to the system, which can readily be utilized, and thus which will protect the other proteins of the body. However, we must realize when giving these amino acid solutions, that the solutions should contain the essential amino acids, as well as sufficient quantities of these, so that they can be properly utilized. Several such preparations

are available and are becoming well known. These are the solutions which are prepared by the hydrolysis of casein. The hydrolysis suitable for the preparation of amino acids is carried out by either enzymatic or acid hydrolysis; in the latter case tryptophane must be added, since this essential amino acid is destroyed in the acid hydrolysis process.

Their use is advocated in cases of liver disease. The basis for their use is found in the vast amount of experimental and clinical work which has shown that diets high in protein have a marked protective action on the liver and cause a more rapid regeneration of liver cells. They protect the liver because in cases of increased demand for proteins in the repair of other tissues following trauma or surgery, the liver proteins are the most readily available and are broken down into their component amino acids and utilized where needed.

Severe reactions have been reported when amino acids have been administered to patients with liver disease, but this apparently occurs only when the liver has been severely damaged and not enough functioning liver cells remain to handle the large influx of amino acids. Normally this large influx of parenterally administered amino acids disappears from the blood stream in a relatively short time and is utilized where needed or deaminized by the liver and excreted in the form of urea by the kidneys.

In conjunction with this problem of liver damage and liver disease, I might state that certain preparations of amino acids are now appearing with 3 per cent methionine added—one of the so-called essential amino acids. There is some evidence at hand that indicates that methionine is of value in liver regeneration so that, when given in cases of liver damage, this type of preparation may be of more value than the ordinary amino acid preparations.

The use of parenteral amino acids in cases of chronic hypoproteinemia is no longer questioned. I say "chronic" hypoproteinemia in distinction from "acute" hypoproteinemia, as occurs in shock and hemorrhage, since in the latter case protein as such is needed rapidly and there is not time for it to be synthesized from the amino acids. Then, of course, whole blood or plasma should be used to overcome the immediate effects of the acute protein loss. Any persisting chronic hypoproteinemia can be taken care of later by the synthesis of new proteins from their component amino acids. One very important fact was not recognized in our early investigations in amino acid therapy. In chronic hypoproteinemia we recognized the condition by blood plasma determinations. The fact is that lowered blood plasma is only a small part of the picture of chronic hypoproteinemia, for with each 1 gm. lowering of the blood plasma, there is approximately a 30 gm. lowering of the other body proteins; and, likewise, to elevate the blood plasma 1 gm., we must supply 30 gm. of proteins for the rest of the body. With this in mind it can be seen that the problem of correcting chronic hypoproteinemia is far more reaching than merely correcting a lowered plasma level. Materials for the rebuilding of the more vast general body proteins must thus be supplied. Consequently, in severely depleted patients the treatment and the return of plasma protein levels to normal will necessarily be prolonged.

Method of Administration

Recognizing then that amino acid therapy is considered a good and important form of therapy, we next ought to consider certain points in the utilization of amino acids to get the best results and the most good from that which is given.

In order to study the effect of amino acids or protein, we do so by a study of the nitrogen balance, that is, the relationship between the nitrogen taken into the body in the form of protein and amino acids and that excreted in the urine and feces. When the nitrogen intake and output are equal, the body is said to be in nitrogen balance, or equilibrium. If the nitrogen intake exceeds the output, the body is in positive nitrogen balance, that is, it is getting more than adequate amounts of protein. If the output exceeds the intake we have a negative nitrogen balance, indicating that not enough protein or not the right kind of protein is being supplied and body proteins are being broken down.

The bulk of the dietary nitrogen is contributed by the proteins in food. When giving amino acids parenterally, a complete mixture of the essential amino acids is able to replace the food protein, and the nitrogen balance is maintained. If any of the essential amino acids are removed from the amino acids mixture, a negative balance ensues immediately, since the other amino acids can then not be properly utilized and much is excreted as urea.

Nitrogen balance can be established at different levels of protein consumption. Thus an adult who habitually eats a diet rich in protein may be in nitrogen balance even though daily he consumes food containing 20 to 25 gm. of nitrogen. If the same individual changes to a diet of lower protein content, the nitrogen excretion gradually diminishes until nitrogen equilibrium is established at a lower level of nitrogen intake. In growing individuals, the body mass of protein is increasing and nitrogen balance is normally on the positive side, that is, more nitrogen is being consumed in food than is being eliminated. On the other hand, in starvation, malnutrition, fever, and wasting diseases, a negative balance is the rule. Here more nitrogen is being excreted than consumed, indicating destruction of body proteins.

It is our feeling that the most important point to remember when using amino acids is its relationship to the metabolism of carbohydrates. The protein-sparing action of carbohydrates is a well known metabolic fact. Thus it is well established that the amount of nitrogen required by an individual to maintain nitrogen equilibrium is within certain limits determined by the caloric intake. The metabolic basis for this lies in the fact that if inadequate fuel is available for the energy requirements

of the body, the amino acids are deaminized and the resulting alpha keto acids are oxidized. This process has been called gluconeogenesis. The ammonia formed as a result of deamination is converted into urea in the liver. This latter reaction is irreversible, and, consequently, this nitrogen is lost to the body and excreted. Because of this fact a minimum daily caloric intake in carbohydrates of 800 to 1,200 calories should accompany the parenterally administered amino acids.

Through some experimental work in nitrogen balance studies performed by Drs. Anthony R. Curreri and Philip Cohen and myself, we made some very important and interesting observations which have aided materially in a better utilization of these parenterally administered amino acids. It has long been a known fact that the most immediate source of energy to the cell is its store of carbohydrate in the form of glycogen and that an adequate calorie intake insures the maintenance of an optimum supply of this readily available fuel. What is probably not realized, and is most important, is that the amount of glycogen which is thus stored in the cell is sufficient to last only a matter of twelve to fourteen hours in normal people. Thus with an inadequate carbohydrate or calorie intake, the depletion of stored glycogen may result in the inability of the cells to carry out such reactions as protein synthesis. As a matter of fact, in the case of the liver, not only will there tend to be a failure of protein synthesis in the absence of glycogen, but there will be an increase in the rate of deamination of the administered amino acids and the products thus formed used for energy requirements. In other words, the opportunity for utilizing amino acids for protein synthesis will be minimal and the nitrogen output will be increased, making it practically impossible to establish nitrogen balance. This very point is most important in patients who have been on an inadequate carbohydrate intake due to their disease, for they do not have glycogen supplies to last twelve to fourteen hours; consequently, they are completely depleted of their glycogen supplies in the hours between their parenteral feedings and use the first amino acids given for energy requirements.

With these facts in mind, and with the findings that parenterally administered amino acids brought patients into nitrogen equilibrium with difficulty in so many of our cases, we undertook to study this relationship between the time of administration of the amino acids and the time of administration of the carbohydrates for their caloric value. As a result of this study, we found that to get the best utilization of administered amino acids, it is necessary to administer glucose to a patient an hour or two before administering the amino acids. By doing this, the glycogen supply is first built up and then the administered amino acids are utilized for building up the body proteins and not deaminized and used for energy requirements. Thus it is our suggestion that the parenteral administration, either subcutaneously or intravenously, of 1,000 cc. of 5 or 7½ per cent glucose be given an hour or two before the parenteral administration of amino acid solution in an effort to build up this needed body glycogen. By doing this a greater amount of the amino acid will be available for protein synthesis, and less will be deaminized and excreted as urea.

Dosage

With this in mind, the question of dosage next arises. It has been more or less definitely established that when the only source of nitrogen is to be that of parenterally administered nitrogen, a minimum of 75 gm. of amino acids daily, as a maintenance dose, should be given, observing the usual precautions of giving it slowly (not more than 50 gm. per two and one-half hours) and being sure that a new bottle is used with each administration, discarding any solution that remains. Where hypoproteinemia is present, and we are attempting to build up body stores, 100 to 125 gm. can be given daily without difficulty. Attempts to give daily higher doses prove to be quite impractical and uncomfortable as far as the patient is concerned.

Conclusion

In conclusion, I would like to say that we must use this new therapeutic method with judgment and caution. Reactions do occur, but certainly are at a very minimum if the precautions which manufacturers give are observed. With proper usage, there is no question in my mind that many more lives will be saved, and surgery will be possible in more patients sooner and under better conditions than would otherwise have been present. It is not a cure-all or panacea for all the cases of protein disturbances, but it is certainly a valuable adjunct to our therapeutic armamentarium.

NAVAL REGISTRATION AT A. M. A. CONVENTION

A registration desk will be available at the American Medical Association convention for the use of medical officers of the regular Navy and Naval Reserve, during June 20–27. Recent announcements and other pertinent information pertaining to the Medical Corps of the Navy will be available. Physicians are asked to register early and give former shipmates an opportunity to contact them during the convention.

Occupational Medicine, Past and Present*

As It Concerns Management, the Worker, and the Medical Department, Doctor, and Nurse Alike

By ELSTON L. BELKNAP, M. D., F. A. C. P.
Milwaukee

E. L. BELKNAP

Doctor Belknap, associate professor of medicine at Marquette University School of Medicine, graduated from Johns Hopkins University School of Medicine in 1923. He interned at Johns Hopkins Hospital and served as assistant resident in the department of medicine at the Henry Ford Hospital, Detroit. Since 1927 he has been practicing internal medicine in Milwaukee. He is also head of the occupational medicine division of the graduate department of Marquette University School of Medicine.

THOUGH at first glance this title sounds all-inclusive as well as time consuming, many medical schools devote from twelve to thirty-six hours to teaching it, and it must be here compressed into a much shorter period. The real subject of the evening, the goal toward which we are all working, can be very briefly and simply stated, namely, "The Health of The Worker," or "How to Keep the Worker Well and at Work."

Industrial Medicine is Preventive Medicine

Management knows that ill health in the worker slows up production and cuts dividends. The worker knows that health is precious because the lack of it means that his family may go hungry. The doctor and nurse in industry as in private practice, as a matter of professional training, are primarily interested in keeping their patients well. Johnstone states that 70 per cent of industrial medicine practice is preventive medicine.[1] Finally, if the worker is made ill by a work process, the Wisconsin Industrial Commission will see that he is reimbursed. This furnishes the essentially necessary drive of enlightened self-interest.

However, not only do we all have the same objective, that of keeping the workman at work by keeping him well, but all of us have the same work-place, the factory and workshop. It sounds dangerously simple, and it need not be complicated if we all work together as a team. Really, all we have to do is to remember to put into action a simple procedure represented by the equation "facts plus teamwork equal health."

Just how can we complete this equation? First, we must face facts. To face facts, we must first assemble them, not alone by reading books or reports, but by going out and seeing for ourselves. We can begin by a plant tour or in-plant clinic as has already been sponsored by the State Medical Society of Wisconsin and Dr. P. A. Brehm of the State Board of Health here and in other counties. This will involve preliminary planning, to be sure. Then actual contact and exchange of ideas out in the plant between foremen and doctor or between nurses and worker are likely to be of the greatest importance.

This process of assembling health facts firsthand out in the factory or workshop is not new. Over two hundred and fifty years ago, Ramazzini, a gifted and learned Italian physician, besides his lucrative court practice, felt it his duty and privilege to study the "diseases of artificers," or workers. He was not too proud to descend into the pit by the side of the workmen so he could himself experience and understand the grievous and pitiful conditions under which the so-called lower classes were then forced to work. Let me quote from his large volume on the subject of the diseases of the worker, or artificer:[2] "The plan of this work compelled me to make repeated visits to the workshop in order to explore thoroughly the exciting causes of the diseases to which workers are exposed," and also "Accordingly, I have tried to unearth in the shops of craftsmen, for these shops are schools whence one can depart with more precise knowledge, whatever may appeal to the taste of the investigators and, which is the main thing, to suggest medical precautions for the prevention and treatment of such diseases as usually affect the workers."[3]

Physicians Must Ask: What Is Your Occupation?

Ramazzini, two and a half centuries ago, was also concerned with the lack of interest of his medical confreres in the diseases of the worker. As a matter of fact, it has been only thirty or forty years, or since the turn of the century, beginning with the pioneer work of Sir Thomas Oliver in England and our own beloved Dr. Alice Hamilton of this country, that the medical profession has begun to ask the patient with any interest or frequency, "What is

* Presented before the Rock County Medical Society on March 31, 1948 in cooperation with the Committee on Industrial Health of the State Medical Society of Wisconsin and the Industrial Hygiene Unit of the Wisconsin State Board of Health.

your occupation?" In fact, in only a few medical schools in this country, in the past five to ten years, have we begun to insist that medical students, regardless of their expected specialty, be trained to include in their history-taking that all important question as Ramazzini asked it, "Of what trade are you?" More recently, we have actually taken some of these shining men-in-white right out into the factory even though there they may be spotted with oil or dust. They may even be disturbed by the strange smells, noises, and apparent confusion, all things that are inevitable with the terrific drive of production industry. To be sure, after one such experience, some are only too glad to retire to the quiet of their laboratories or consulting rooms. Many more are thrilled by new visions of preventive medicine as they see the actual working conditions demanded by our modern chemical industry.

In industrial medicine, we are not dealing with purely theoretic problems, but have to come down out of our ivory towers of pure medical science. Together with management and engineers, we have to roll up our sleeves and study the work conditions of the men as they work with dusts, fumes, vapors, and gases, as well as dirt and grease, those conditions under which many of us might refuse to work.

Industry Needs the Doctor

Passing rapidly through the centuries from Ramazzini of two hundred and fifty years ago, we see a new spirit in industry, as the late Doctor Lazenby, former medical director of the Maryland Casualty Company, wrote, "Industry has finally become medically conscious." He then urged physicians actively to participate in the health problems of industrial life. Going on, he said, "New substances are constantly being introduced into industrial processes with certain known and many unknown effects upon the worker exposed. Newly created laws dealing with control of and compensation for certain diseases of industry have focused the attention of industrialists, labor leaders, and physicians as well, upon the so-called occupational diseases. There are more than 900 occupational exposures to toxic materials and conditions, many of them affecting the health of the worker adversely. Industry deals with men as well as with machines and material, and the man who runs the machine and molds the material is after all the most important element of the three. Already, many industries regard their plant physician as of equal importance to their plant and maintenance engineer. They regard the task of conserving their man power, keeping it in good repair and keeping it constantly on the job as of equal importance to the constant adjustment and maintenance of their machines and equipment. For this, industry needs the doctor." [4]

Doctor Lazenby closes with several more important statements: "The industrial medical department must function as a part of the practice of good business and good medicine and not as philanthropy. It must be a hard headed business step towards improving men and women productively, just as the installation of a new machine or a new process will increase plant productivity. The introduction of medical service into industry is not an easy task. We are not, as is commonly supposed, a nation of big industries. More than 98% of all the industrial plants in this country employ less than 500 men." So says Doctor Lazenby.

Doctor Should Study Both Worker and Work Place

Indeed, since the day of Ramazzini and the ancients, we have come a long way from merely watching grievous working conditions so that we as physicians have learned to work with the engineer in preventing dangerous industrial exposures. We have learned to our cost that we must not wait until a worker has a full-blown textbook disease picture, but must study him periodically for very early symptoms and signs while he is still in a nondisabling state of absorption. Thus we as skilled physicians of industry must try to understand the work processes from firsthand observation so that we can recommend protective procedures which will actually reduce the exposure and thus prevent the absorption of toxic substances involved.

Above all in our industrial medical contacts, we must maintain, as of primary value, the all important relationship of the doctor and patient. We must never forget that our first responsibility is for the welfare of the patient. It is well that the Wisconsin Industrial Commission recognizes this principle of the relationship of the doctor and worker as a most basic one.

To be effective, we must work carefully to gain and maintain the confidence of the worker. For example, if he has a lead line we must tell him so frankly, hoping he may help us reduce further lead absorption. We must make him realize that we welcome intelligent cooperation on his part so that he may take advantage of and even improve the protective devices which we and the engineering department work out for him.

We must always work against the recurrence of a toxic exposure by making definite recommendations to the management when our frequent periodic surveys out in the workshop and factories have accumulated significant facts. It is not necessary that we physicians have special engineering training for this, but it is essential that we must use the seeing eye and simply apply keen common sense to our study of actual factory working conditions just as we analyze the pathologic facts in the disease picture of any patient in our private practice.

Let us now take some concrete examples of what we can learn by developing all our senses as we step out into the workshop and make our firsthand tour of factory conditions. In any workshop, however small, there may be toxic "dusts, fumes, vapors and gases," as the Wisconsin Industrial Commission enumerates them.[5]

Lead is the Most Common Toxic Dust

As an example of a toxic dust, lead dust in its various forms is probably the most common poisonous material of modern industry. It is used in more than one hundred and fifty of our industries.[6] I am not going to enumerate the common sources of such hazard which are led by the wet storage battery industry, but I should like to mention in more detail some types of work in which lead poisoning appears where it is least expected. Lead absorption may develop very rapidly from dismantling and torch cutting of thickly painted structural steel or old ships. Metallizing or lining steel pipes or tanks by blowing lead fumes over them is a very difficult form of lead exposure to control. Perhaps an even more serious and more frequent source of lead absorption is the smoothing down of all-steel welded auto bodies by grinding down with machine abrasive wheels the lead solder paste which has been slapped on to fill up the welding irregularities. In many large manufacturing establishments, this technic is so difficult to control that management has been forced to return to the old hand-filling method where the particles of lead are too large and too heavy for inhalation.

Certain medical experts have said that there is no lead hazard in handling brass. However, I have found actual proof of lead absorption shown by lead lines, high stippled cell counts, and even lead palsy in men who saw brass or tend brass furnaces. Even though brass may contain only from 3 to 15 per cent lead, it is obvious that when lead, which volatilizes between 900 and 1000 degrees, is put into the melting pot along with copper, which does not melt below 2000 degrees, there must be lead oxide fume in the air. This hazard can well be controlled by exhaust ventilation and by the wearing of respirators.

The efficiency of such protection, however, should be checked by monthly physical examinations for lead line of the gums as well as by blood examination for hemoglobin and stippled cell count.

We have been talking about lead as an example of dust and also as a hazard from the inhalation of lead fumes. We should not omit the mention of the hazards of mercury and cadmium fumes.

Mercury Poisoning Mimics Intestinal Flu

Toward the end of the last war, the second world war, I had occasion to be called in to study alarming symptoms in a small group of men engaged in the manufacture of bichloride of mercury to be used in high-power, dry batteries for the signal corps. According to the first reports, the men were simply having attacks of severe intestinal influenza with diarrhea, abdominal cramps, and very foul breath. My investigation firsthand showed that, while there should have been no hazard present, actually the quantities of mercury compounds, dust, and vapor were so great that the ordinary apparatus testing the air for mercury could not indicate the excess amount. This was due to production speed-up demanded by the exigencies of war, when quartz retorts constantly broke. During their replacement the men neglected to protect themselves with the respirators which were offered for such emergencies and consequently inhaled overwhelming amounts of mercury, dust, and vapor.

Cadmium Fumes Attack Alveoli

Another fume which can be often much more dangerous and which usually occurs by accident in industry, is that of cadmium, a metal increasingly and harmlessly used for plating. However, when cadmium is heated by accident to the point of fuming, it may be inhaled very deeply into the lungs without any warning spasm of the larynx. Several hours later the worker may be wakened from a sound sleep by a choking discharge of fluid in his lungs which if untreated may often go on to cause an agonizing death by suffocation. Recently in an English journal on occupational medicine I noted an exceedingly interesting article upon this subject of death from cadmium fume inhalation.[7] A fire had developed in a small shop at night when no workmen were present. Firemen, on entrance, unfortunately were not protected by respirators or hoods and combated the fire and smoke in the usual manner. A few hours later, several men were overcome and 1 died. A postmortem showed that he must have died of cadmium poisoning. The cause of this was obscure, particularly as the fire had been very small and located, in fact, only at one work bench which the fire consumed entirely. Underneath the bench were found the remains of a small box which contained a number of small cadmium plated castings. The intense heat of the burning work bench had generated cadmium fumes which the firemen had inhaled. The fumes then caused pulmonary edema, just as is caused by the inhalation of phosgene, one of the most terrible of the war gases.

Benzol, Though Cheap Solvent, Is Worst Hematotoxin

Beside toxic dusts and fumes, by our sense of smell and by our knowledge of chemical processes, we must be put on the alert for vapors which may arise from the use of solvents and thinners. Some of these are harmless, but many are extremely toxic. I will cite only two. Not so long ago a young man was referred to me because of his complaint of headache which developed while he was splashing solvent upon some small motors to clean them of grease. A blood cell count taken showed that his white cells were reduced, and I suspected one of the most toxic substances, the solvent called benzol. This may damage the bone marrow so seriously that no white cells and eventually no red cells are formed and the individual dies of an overpowering infection. It was fortunate that his concentration of exposure was so great that a headache developed the first day of his work demanding an investigation. On

going to the plant I asked the name of the solvent and the foreman honestly claimed ignorance. I asked him, however, if he could show me the stock-barrel from which the material came. The superintendent was called, and presently I was led into a small unlighted garage where the solvent barrels were stored. By the use of a flashlight, we were all somewhat astounded to read in large letters on the end of the stock-barrel "Benzol-Poison." This is an example not only of a serious hazard, but of the importance of not trying to minimize the seriousness of the hazard.

Carbon Tetrachloride Is Fatal Nephrotoxin

Another time I was called to a hospital to see a young man of 30, a day or two before he died of high blood pressure, blindness, and signs of complete kidney insufficiency. From his family and employer, I was able to uncover the following story. His occupation had been that of relaying old linoleum. To do this he had to remove the old cement with gasoline as a solvent. He had used this for ten years with no symptoms. One morning, however, he was furnished with a gallon of a substance which he was told would be much more effective than gasoline. This had been sold to the employer, incidentally, by an enterprising druggist. With the gallon of the new linoleum cement remover, he spent one day in a small unventilated room in the basement on his hands and knees. At the end of that time he had used up the entire gallon. The solvent was later found to be carbon tetrachloride, slightly heavier than air and therefore more dangerous at floor level.

Arsine Is More Deadly Than Cyanide

As an example of the fourth type of industrial poisoning, namely, that caused by a toxic gas, I would like to cite the following very recent experience. A young man of 18 had been working darkening metal in a small shop in a small town up in the state for several months. To do this he dipped aluminum castings into a bath of white arsenic and hydrochloric acid. One morning he did this eight times over a period of two hours, totalling about ten minutes' exposure. It was later found that the castings had been changed to about 98 per cent zinc instead of aluminum. Later that evening he became seriously ill and was treated with BAL, the British anti-lewisite drug, with the thought that perhaps he had contaminated his fingers handling the arsenic. A consultant was called to see the patient and he was also asked to investigate and witness the actual work process. This seemed to be an entirely inadequate cause of the boy's serious condition with the rapid secondary anemia and associated jaundice. A few whiffs of less than half a minute convinced the consultant that there was being evolved in this process that most dangerous of all gases, arsine, a gas formed by the combination of hydrogen and arsenic. The hydrogen was liberated from the hydrochloric acid especially in the presence of zinc. It was identified by a very faint moldy, garlicky odor. The gas is about twenty times as toxic as hydrogen cyanide, and only one part per million is designated as the safe threshold. By the next day, both the consultant and the foreman who had shown him the process had arsine poisoning.

I am reluctant to say that I was the consultant in this case, though I had an unusual opportunity to make a number of observations based on firsthand experience as to both the symptoms of arsine poisoning and the treatment necessary to control it. Fortunately, BAL, prepared to combat war gas poisoning, is a specific antidote for arsenic and arsine poisoning and had just been available for civilian use. Arsine poisoning is always accidental in industry and usually appears at most unexpected times. A much commoner form of the toxic gases is, of course, carbon monoxide, the dangers of which even laymen recognize.

Physician Is the Key Figure

The first principle of control of worker health with which the physician in industry must acquaint himself is this knowledge of the mechanism of absorption and actions of poisonings of many different types. Here as in other medical fields, the physician is the key figure and must realize that he is the expert on whom industry must rely. Of course, if the physician is able to give no answer, industry will naturally turn to a layman for advice. If the physician does not have the initiative or interest to keep himself abreast of new developments in the chemistry of industry, he must not be surprised if he is relegated to a position of secondary importance. Therefore it behooves the physician to be informed if he would retain this hard won commanding position.

Occupational Medicine Is Broad as Internal Medicine

Occupational medicine, as practiced now, is certainly not a narrow specialty. One cannot work long with it before he finds that it demands all the medical skill which one uses in the other branches of medicine. Special training is needed for the diagnosis, treatment, and estimate of temporary and partial permanent disability both from injury and occupational disease. Of even greater importance, however, are preemployment, inventory, or placement, physicial examinations as well as periodic examinations given to prevent disability in industry. These require a full knowledge of general medicine. As physicians, our responsibility is not only to diagnose and treat the poisonings in industry, but also to advise the industrial commission, the employer, and the worker whether there has been permanent damage from the poison absorption and, if so, how much residual damage in actual percentage. This is not so simple as estimating percentage range of motion lost

as compared with amputation. It involves detailed study of functional reserve of the heart, liver, and kidney, a challenge to the best practice of general medicine. Even though a physician does not limit his practice to occupational or industrial medicine, he will be much better able to render proper service to his patient if he always remembers to ask himself this question "What is the occupation of my patient? Is this case of acute belly pain appendicitis or lead poisoning? Is this acute pulmonary edema due to heart failure or is it a cadmium fume intoxication? Is this severe anemia, pernicious anemia or is it benzol poisoning? Is this case of apparent acute Bright's disease with swelling of the feet, high blood pressure and blindness perhaps carbon tetrachloride poisoning? Or is this case of jaundice, severe anemia due to an acute gallbladder, or is it perhaps actual arsine poisoning?"

Doctor in Industry Deals With Art of Medicine

As long as we have industry growing more complex each day, we physicians must be informed as to the chemicals used in industry. We must be familiar with the technics and hazards of industry so we may be forewarned. We must not remain aloof in our laboratories as the shrines of abstract science of medicine. We must work with the worker and the engineer in their work-places if we are to prevent industrial disability. We must remember that here, as in the practice of general medicine, we are dealing with the art of medicine. Just as urged on us hundreds of years ago by Hippocrates and Ramazzini there is no single step by which we can short-cut our study of the whole picture of disease.

The prophylactic control of poisonings or disease process in the worker at work is the goal of every industry, management, engineering and medical department, and certainly of every physician who qualifies himself to act as a consultant in occupational medicine.

Facts Plus Teamwork Equal Health

While we must not expect a nurse to diagnose or treat diseases, a plant physician must rely constantly upon his able assistant, the plant nurse, for suggestions and observations.

Besides regular first aid care of accidents and general employee health complaints which fill the usual industrial nurse's day, a nurse at a plant where the use of potentially toxic materials is involved has an added and important responsibility.

Only through a constant check of facts and close application of an attitude of teamwork, is it possible to support a program of health control by means of respirators, ventilation, physical examinations, and laboratory records.

Respirators are somewhat uncomfortable. No one volunteers to wear one. But when he knows the reason underlying its use, the worker will cooperate.

Men may forget to put on their respirators and ventilating equipment may break down, but the medical inspection of a man's condition can often recognize a situation of this sort before it is actually dangerous. The result is that the exposure can be corrected before there is any problem of disability.

That is the way we can complete the equation "facts plus teamwork equal health."

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STATE BOARD OF MEDICAL EXAMINERS TO HOLD EXAMINATIONS

The State Board of Medical Examiners has announced that it will hold written examinations on June 29 and 30 and July 1 at the Hotel Plankinton in Milwaukee. Applicants should contact Dr. C. A. Dawson, Chairman, State Board of Medical Examiners, River Falls, Wisconsin. Those requiring hotel accommodations should make reservations as early as possible, and, if these are made at the Hotel Plankinton, the hotel should be informed that the applicant is appearing before the Board for examination.

Oral examinations for reciprocity applicants will be held on June 30. Appointments may be made by contacting Doctor Dawson at River Falls.

The So-Called "Connell Suture"

By F. GREGORY CONNELL
Oshkosh

F. GREGORY CONNELL

Doctor Connell, recipient of the 1947 Council Award, has practiced medicine for fifty-one years. A graduate of Rush Medical College he was president of the State Medical Society in 1923 and from 1922 to 1931 was councilor of the Sixth District. He has been the author of numerous articles in medical publications and is at present president of the newly-formed Wisconsin Surgical Society.

AT A luncheon of the ex-presidents at the One Hundred Sixth annual meeting of the State Medical Society of Wisconsin and on previous occasions, I was asked (because of confusion relative to the so-called "Connell suture") to publish the history of its origin and development. After membership in the "Fifty Year Club" it seemed ethically permissible to acquiesce to this request.

In his book, "Practical Surgery," N. Senn[1] stated, "Dr. M. E. Connell, Superintendent of the Milwaukee County Hospital, suggested the use of perforated plates for making the lateral apposition in place of suturing."

There is no date given, but I can remember various "plates" made of different material and their experimental use in dogs, under general anesthesia, during my high school days, 1888–1892.

At this time, the subjects of abdominal surgery and gastrointestinal suturing were in their infancy and subjects of discussion and much controversy, especially so in Milwaukee, where Doctor Senn with Dr. William Mackee, my father, M. E. Connell, and their assistants, conducted many series of animal experiments in intestinal anastomosis and abdominal surgery.

The most spectacular of these experiments was Senn's[2] rectal injection of hydrogen gas as an "infallible" method of determining whether the gastrointestinal tract was intact after a gunshot wound of the abdomen. If so, the gas made a harmless passage and escaped at the mouth. "If a perforation existed, then after causing tympanities, the gas was found to escape at the abdominal wound, where it was recognized by its being ignited and burning with a characteristic blue flame."

This shooting of an anesthetized animal, the injecting of hydrogen, the igniting of the gas, and the following laparotomy with closure of perforations by various methods of suture or plates were most dramatic, and its demonstration by Senn, both at home and later on a tour of Europe, was naturally very impressive and attracted much attention and discussion.

In 1898 Senn[3] stated, "The writer has shown by his experiments on animals, and later by his clinical experience in the treatment of a number of cases of gunshot wounds of the abdomen that rectal insufflations of hydrogen gas can be relied upon in demonstrating the existence of perforations of the gastrointestinal canal before opening the abdomen."

Despite the above statement the hydrogen gas test for gastrointestinal perforation was not accepted. But the study of gastrointestinal suturing proved to be of real value.

Among the many distinguished visitors who attended some of these demonstrations, I remember Christian Fenger, Bayard Holmes, Charles T. Parkes, Bertram Sippy of Chicago, Robert H. Dawbarn, Thomas Manley of New York, Harvey Reed of Ohio, Junus Jackson, J. A. Pelton, F. S. Wiley, C. W. Oviatt from Wisconsin, and students of N. Senn, at his office and Passavant (now called Milwaukee) Hospital.

There were many others. As a boy I kept an autograph album and asked for signatures of visitors, which, unfortunately, was later lost in a fire of my parents' household goods. But the outstanding visitor was Prince Von Esmarck of Germany, who came to Milwaukee as a guest of N. Senn. His visit created much excitement in social and medical circles. His contribution to my autograph collection was "*kurtz und buendig*, E. Von Esmarck." The sentiments expressed by others are not remembered.

In 1892 and in 1893 at the Milwaukee meeting of the American Medical Association,[4] M. E. Connell presented a paper describing "a continuous right angle stitch penetrating all coats with the knot and suture buried deeply between the coapted surfaces." My mother, Anna Gregory Connell (also an M. D.), superintendent of one of the earliest nurses' training schools in the United States, at the Milwaukee County Hospital, being an expert seamstress as well, had an important part in the development of this method.

Despite satisfactory results by M. E. Connell, Thomas H. Manley, and others, this method was not accepted because of a danger of infection of the peritoneum from the lumen of the bowel by a possible "seton action."

The two row Czerney–Lambert and many other methods of suture, the bone plate, other mechanical contrivances, and the Murphy button became popular.

The satisfactory results that followed the fundamentally important detail of inversion with "sero-

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serous apposition," led me to attempt arterial end to end suture by flaring the divided ends and reunion by eversion with endothelial to endothelial apposition.

These experiments were unsuccessful and unreported and were carried out at the Chicago Post-Graduate Medical School, at about the same time that Alex Carrel was studying the same problem at the University of Chicago.

Because of my early contact with and "exposure to" the subject of intestinal suturing, I was naturally interested in its subsequent development.

After graduation in 1896, while lecturer on surgery and assistant demonstrator of pathology, University of Illinois College of Medicine, Chicago, in 1899 I was awarded a prize by the Philadelphia Medical Journal[5] in 1899 for an essay entitled "Intestinal Sutures, Some Old, Some Not So Old and a New One."

As a preface, I quoted from N. Senn as follows: "We have reason to believe that the technic of intestinal surgery remains an unfinished chapter and that the ideal method of uniting intestinal wounds has not yet been devised."

The "new" method obviated the objection of the possible seton action of the M. E. Connell method, by placing *all* of the knots (the last one by a trick maneuver) upon the mucosa within the lumen of the bowel *instead* of upon the serosa surface within the peritoneal cavity. This met with rapid acceptance by the surgical profession.

The first clinical case was operated upon by Dr. Franklin H. Martin. Dr. E. Wyllys Andrews reported 4 cases; Alex Hugh Fergeson, Christian Fenger, A. E. Halstead, W. E. Schroeder, Emil Ries, and D. A. K. Steel were among the early users of the method.

In November 1900 I was invited to demonstrate the method before the Detroit Medical Society.

The Senn Medal award in June 1900 at the fifty-first annual meeting of the American Medical Association was not related to intestinal suturing. It was for a report upon "Extrophy of the Bladder"[6] with experimental transplantation of the ureters. This medal was donated by Dr. N. Senn, and the committee of judges was W. W. Keen, A. J. Ochsner, and William L. Rodman. The only other recipients, so far as I know, were George W. Crile of Cleveland and J. L. Yates of Milwaukee.

William S. Halsted of Johns Hopkins Hospital, a pioneer in intestinal surgery, had in 1891[7] directed attention to the tensile strength and consequent importance of the submucous layer of the bowel wall in intestinal anastomosis.

In speaking of this coat he said, "It is remarkable that no one has recognized the important part which this coat should play in operations for intestinal suture: it is still more remarkable that surgeons could have altogether overlooked the existence of the submucosa; and it is perhaps most remarkable that experimenters and writers on the subject of intestinal suture should without exception believe that it is possible to take a stitch of the peritoneal coat alone. The crude views of Jobert and Lembert as to the construction of the wall of the intestine have been universally accepted by surgeons up to the present time. The peritoneal coat is believed to be thick enough and sufficiently strong to hold a stitch and the existence of the submucous coat has been ignored."

This point was also emphasized by Howard Kelly. He states, "Regarding the fibrous coat of the intestine, the most valuable contribution which has yet been made to intestinal surgery is the demonstration by Dr. Halstead, of the fact that the essential feature in suturing or anastomotic operation is the employment of the submucous intestinal coat."

In 1901, at the fifty-second annual meeting of the American Medical Association,[8] I presented a paper entitled "The Knot Within the Lumen in Intestinal Surgery; with Report of Nineteen Cases."

In this paper, attention was called to the fact that as early as 1843 Samuel D. Gross, then of Louisville, in a monograph entitled, "An Experimental and Critical Inquiry into the Nature and Treatment of Wounds of the Intestine," in speaking of the submucosa said, ". . . it is the membrane through which the surgeon should always carry his needle in sewing up wounds of the intestine."

The location of the knot within the lumen permitted retention of the *security* of the stitch through the submucosa but obviated the alleged danger of the contamination of the peritoneal cavity by capillary extension from the mucosa and the lumen.

In Doctor Halsted's original article is to be found a detailed description of the technic employed, which enables one to insert the needle in such a manner that the submucosa is "penetrated but not perforated." This feat was illustrated by a schematic drawing of the intestinal wall, showing the relative thickness of the various layers, with the needle in the act of picking up a part of the submucosa without penetrating into the lumen. But the drawing was incorrect, in the failure to magnify the needle equally with that of the intestinal wall. Had this been done, the diameter of the needle would have been six times as large as the width of the submucosa, obviously making impossible the recommended penetration without perforation of the submucosa.

In my paper attention was also directed to the location of Brunner's gland in the *submucosa* of the duodenum (which had been previously overlooked). Suture of the duodenal submucosa would rarely, if ever, avoid these glands, with their direct communication with the lumen.

After this, intestinal stitches, including the *entire* submucosa *for security*, became routine practice.

In 1902 I was invited to present the method at the Portland meeting of the Oregon State Medical Society.

After my removal to Colorado, at the Mississippi Valley Medical Association in October 1902,[9] I presented a further report entitled, "Through and Through Intestinal Suture with Report of Additional Cases."

At one of the first scientific exhibits at a meeting of the American Medical Association, which subsequently became a most important department of these annual gatherings, the method of suture with the final knot located in the lumen was demonstrated by means of clay models, which with the illustrations in the many publications were the work of my late wife, Isabella Stickney Connell. These models were subsequently presented to the Medical Division of the State Historical Museum at Madison.

In 1906, at the fifty-seventh annual meeting of the American Medical Association at Boston,[10] I discussed "Capillarity in Intestinal Suturing."

In 1909[11] I discussed the "Principles of Intestinal Suturing."

It gradually became realized that to bring the last knot deep between the serosa by a superficial seroserous stitch, as originally recommended by M. E. Connell in 1893, was satisfactory and made unnecessary the extra technic to place the knot on the mucosa within the lumen.

Suture through all coats for security and the seroserous apposition *for protection* against infection, became and have continued to be the generally accepted method of intestinal suturing.

The comparative safety and standardization of this procedure led, at times and in places, to an over-enthusiasm and unjustified use, as in appendectomies for "chronic" appendicitis and gastroenterostomies for duodenal ulcer, which, in turn, led to a shift in emphasis from technic (the how to do), the anatomic factor, to diagnosis (the why to do), the physiologic aspect, of gastrointestinal surgery.

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AMERICAN MEDICAL GOLFING TOURNAMENT

The American Medical Golfing Association will hold its Thirty-Second Tournament on June 21 at the Olympia Fields, Chicago, which has two eighteen-hole courses ideal for experts and players with higher handicaps. Fellows of the American Medical Golfing Association may tee off between 7:30 a. m. and 2:00 p. m. Luncheon will be served at the Club. The Golfers' Banquet will be held at 7:00 p. m., after which prizes will be awarded. Entertainment will follow the awarding of prizes.

Trophies will be awarded for the championship (36 holes) the Will Walter Trophy; the runner-up champion, the Detroit Trophy; the eighteen-hole championship, the Golden State Trophy; and the runner-up eighteen-hole champion, Ben Thomas Trophy. The Section Event will include sterling silver pitchers for eight sections, including internal medicine, surgery, gynecology and obstetrics, dermatology and syphilology, radiology, general practice, pediatrics, eye-ear-nose and throat, and urology. The first flight (0–13) will contain trophies and prizes for both gross and net in 36 and 18 holes, including the St. Louis Trophy, the President's Trophy, the Atlantic City Trophy, and the Sperry Trophy. The second and third flights (14–18 and 19–30) will contain prizes for both 36 and 18 holes. The maturity event, for Fellows 60 years and older, the Minneapolis Trophy; and the Old Guard Championship, the Wendell Phillips Trophy. In addition to these, approximately 75 other prizes will be awarded.

All male Fellows of the American Medical Association are cordially invited to become Fellows of the American Medical Golfing Association. For an application blank write to Secretary Bill Burns, 2020 Olds Tower, Lansing 8, Michigan.

Participants in the tournament are required to present their home club handicap, signed by the Club Secretary, or to accept a handicap set by the AMGA Handicap Committee. No handicap over 30. All 18 hole trophies and prizes are awarded on the basis of scores for the first 18 holes played. A Fellow absent from the annual banquet following the tournament forfeits his rights to a trophy or prize.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Oral Administration of a Mercurial Diuretic

In the department of therapeutics, New York University College of Medicine, a thorough study is being made of the oral method of administering mercupurin, using tablets containing 120 mg. as compared with the 135 mg. per cubic centimeter of the parenteral solution. Employing 5 tablets as a single dose in thirty-four trials in 24 patients, Batterman *et al.* (1946) reported a satisfactory response in 58 per cent of the trials; diuresis usually began within four to twelve hours and with few exceptions was completed in less than twenty-four hours. But these results did not compare favorably with those obtained from intravenous administration. In their multiple dose method 1 to 3 tablets three times daily for two to five days constituted a trial, thirty-nine such courses being given to 29 patients, and a satisfactory response being obtained in 67 per cent of the trials. Diuresis usually developed slowly when the drug was given in this way and in many patients did not reach its peak before forty-eight hours; nevertheless, it was said that the total diuretic response frequently approached that achieved with the intravenous preparation. It was felt that this is not the ideal method for patients in whom rapid removal of edema fluid is desired, but that for those who do not require emergency measures, for those who should have the edema fluid removed gradually, and for those who cannot be given the diuretic parenterally, it is the ideal method. Batterman *et al.* emphasized in connection with this dosage that the relatively poor result was undoubtedly contributed to by the fact that in some instances they deliberately withheld digitalis or ammonium chloride for purposes of comparison, though being convinced that maintenance of digitalis effects as well as simultaneous administration of ammonium chloride are desirable when an oral diuretic is used. Toxicity with this method was of little consequence in hospitalized patients, mild gastro-intestinal irritation of a transient nature being observed in only 2 of the 29 individuals, but gastro-intestinal symptoms were noted in 6 of 13 patients treated on an ambulatory basis. The third, or daily dose method, of Batterman *et al.* consisted in a study of thirty trials in 26 hospitalized patients and thirty-one trials in 18 ambulatory patients, all patients being in progressively severe congestive failure no longer responding to maintenance digitalis, and all with few exceptions having previously received frequent injections of mercupurin intravenously. The 26 hospitalized patients received 2 tablets daily for periods of seven to forty-one days, the ambulatory patients from 1 to 2 tablets for periods of one to forty-nine weeks, patients in both groups being observed with and without the administration of ammonium chloride. Patients responding to the daily dose required four to fourteen days of continuous therapy before the medication became effective, and in some instances it seemed advisable to continue intravenous dosage of 1 cc. until the orally administered drug acted. Of the 26 hospitalized patients, previously uncontrolled, complete removal of the edema and alleviation of acute symptoms were obtained in 15 and very considerable improvement in 4; effective diuresis was therefore considered to have been attained in 73 per cent of these patients. In the ambulatory group such results were attained in 77 per cent of the patients. Toxicity associated with the daily dose most commonly consisted in the appearance of digitalis toxicity due to mobilization of digitalis from the edema fluid at the time of diuresis; such toxicity occurred in 19 per cent of the hospitalized patients and 33 per cent of the ambulatory patients. Gastro-intestinal symptoms, associated with increasing albuminuria, occurred in 3 instances, these being signs of mercurialism in patients who had previously presented evidence of kidney disease; in 1 of these 3 patients the symptoms were associated with severe gingivitis and elevation of nonprotein nitrogen, all of these manifestations subsiding when the diuretic was discontinued. The experience of this group of observers with a few other patients who presented albuminuria while on the oral mercurial diuretic, but no further symptoms of mercurialism, led them to believe that albuminuria itself does not contraindicate the continuation of the use of mercurial diuretics. They said, however, that it has become their policy after the maximum effect of the oral diuretic has been achieved to allow the patient a rest period of a week and then to continue the diuretic for one month, short rest periods thereafter being given between monthly courses. But since 2 patients not of this albuminuria group presented considerable elevations in nonprotein nitrogen associated with the other signs of uremia, it was concluded that the oral mercurial should not be used in any patient who presents impaired kidney function.

In summarizing their findings with this oral method of administering mercupurin, Batterman *et al.* (1946) said that it had its greatest usefulness in patients with congestive failure who had exhausted the value of maintenance digitalis and who, in spite of repeated injections of a mercurial diuretic, reaccumulated their edema or experienced a recurrence of acute symptoms. They said that in such patients the oral diuretic will remove all signs and symptoms of failure, making it possible either to dispense with the intravenous preparation or to decrease the number of injections required. However, Gold (1946) said that he had not often been able to employ oral tablets of the mercurial diuretics with satisfaction, small doses being rarely effective and effective doses soon causing gastro-intestinal upsets. But I do not know how extensive his experience with the oral method had been.—HARRY BECKMAN, M. D.

The
MEDICAL FORUM

The Wisconsin Medical Journal — June, 1948

NEW PRIORITY LIST FOR STATE HOSPITAL PLAN

ANNOUNCE SCHEDULE OF BENEFITS FOR WAUSHARA COUNTY CO-OP PLAN

Prepay Hospital, Surgical and Medical Plan to Start July 1

Wild Rose, Wis., June 2.—A prepayment hospital, surgical and medical plan has been adopted by the Waushara County Cooperative Health Association, Inc., located at Wild Rose, Wisconsin. The plan is to begin operation on July 1, 1948, in conjunction with a prepayment medical-surgical plan. The cooperative is taking over a hospital that is already functioning.

According to reports in the Frederic *Inter-County Leader* the new plan's rates are $2.50 per month for a single head of a household; $4.50 for the head of household and one dependent; $5.25 for head of household, spouse and up to and including 3 minor dependents; $6.25 for head of household, spouse and four or more minor dependents, and $2.00 for additional certified adult dependents living in same household.

Hospital benefits under this plan would include the following for any member who is confined to the hospital operated by the cooperative as a bed patient by order of a licensed physician:

Hospitalization, not to exceed 62 days for each year or for any continuous illness or disability including a ward bed, or semi-private if

(Continued on page 6)

ON THE INSIDE

Subject	Page
Alcohol Studies	5
Dewey	8
Doctor Draft	8
Fifty Year Club	2
Industrial Health Clinics	4
Secretaries' Conferences	7
Stassen	8
Vivisection	6
Warren	8
Wisconsin Plan	3
WVMSA Form 100	2
WVMSA Form 200	6

Five Cancer Clinics Scheduled for July

Will Be Third in Series of Graduate Training Programs

Madison, June 4.—The third in a series of medical training programs designed to keep practicing physicians abreast of the latest medical information and advances will be the cancer clinics for the doctors and public alike at Racine, July 14; Fond du Lac, July 15; Stevens Point, July 16; La Crosse, July 19 and Janesville, July 20.

The series began in late March with industrial health clinics at four cities. These were followed by the annual "spring clinics" or postgraduate teaching clinics held this year at La Crosse, Wausau and Manitowoc. The latter clinics were attended by more than 260 physicians, according to Dr. C. F. Midelfort, La Crosse, chairman of the Council on Scientific Work. Speakers at these meetings were Dr. J. W. Harris, University of Wisconsin Medical School; Dr. R. A. Jensen, University of Minnesota Medical School; Dr. A. A. Schaefer, Marquette University School of Medicine, and Dr. W. O. Thompson, University of Illinois College of Medicine.

Discussions at the cancer clinics will center around tests for cancer, and diagnosis and treatment of cancer of the colon, rectum and cervix. Speakers at the cancer programs will be Drs. H. S. N. Greene, professor of pathology, Yale University School of Medicine, L. W. Paul, professor of radiology, University of Wisconsin; E. D. Sugarbaker, Sugarbaker Clinic, Jefferson City, Mo., and J. H. Randall, first assistant, department of obstetrics and gynecology, University of Iowa School of Medicine.

Area Must Request Funds Before July 1 to Get Aid

Madison, May 15.—The revised priority schedule of the Wisconsin Hospital Construction Plan has been announced by the State Board of Health as the state prepares to take advantage of the federal grants-in-aid which are now available for hospital and health center construction during the second fiscal year of the plan's operation.

Because of the limited funds available for general hospital construction, about $973,000, and the high cost of construction, only a few communities can receive federal aid during any one year. Every dollar of federal funds must be matched by two dollars of local funds.

Each community listed with a high priority rank (at least A or B, see list) must request and submit an official application for aid before July 1, 1948, if it is interested in obtaining federal assistance for hospital construction.

Eligible applicants will be approved in order of priority rank as shown in the schedule so far as available funds permit. This method allows some communities with lower priorities, with funds on hand, to be approved ahead of high priority areas unable to raise the necessary funds. No community will lose its priority rank because it can't raise the money, but may get another chance to participate at the beginning of the third fiscal year, July 1, 1949. Priority ranks may change at any time, however, as a result of hospital construction of any kind within the area.

During the first year of the program approval was given for construction of a total of 326 general hospital beds in six cities—New Richmond (55), Ft. Atkinson (82), Darlington (47), Viroqua (78) and Clintonville (64). Approval was also granted for 265 chronic dis-

(Continued on page 3)

The most recent summary of VA activities shows that on March 31, 1948, only 197 veterans with service connected disabilities were awaiting hospital admission while 21,254 veterans with non-service connected ailments were waiting to get in. At the same time there were 108,058 VA patients in hospitals—26,563 service connected and 70,338 non-service connected. Meanwhile, the VA requested and received an additional 15 million dollars to cover unexpected construction costs for 76 new VA hospitals and 14 converted hospitals.

* * *

Wisconsin pays the federal government five times as much as it expends for its own government, the State Chamber of Commerce reports. It cost Wisconsin $156 million to run its state government last year, but taxpayers paid out another $774 million as their share of the federal government's operation.

* * *

Business and labor are expanding their medical service programs without waiting to see what will happen to public health proposals. The steel, aluminum, automobile and electrical equipment industries are exploring possibilities of industry-wide medical and hospital benefits. There is much disagreement however on the methods by which such plans would be financed.

* * *

The average United States government worker now makes $2,839 a year, the federal civil service commission reveals, as plans are being made to give some 1,300,000 federal employees a raise.

* * *

The VA facilities at Tomah, Wis., are primarily for mental patients, but are doing an increasing amount of general medical and surgical work, according to G. D. Rice, manager. The Tomah hospital has more than 500 employees, over 700 patients and soon expects to increase the number of patients to more than 1100.

GOLD LAPEL PINS GO TO MEMBERS OF 50 YEAR CLUB

Madison, May 17.—Seventy-three Wisconsin physicians who have given more than half a century of medical service to their respective communities were honored recently by the State Medical Society. Each was presented with a gold lapel pin (shown below) honoring him as a member of the "50 Year Club" of the society.

Each member received an engraved certificate and a letter describing the pin as a "symbol of the service and devotion expressed in your long years of practice." The doctors became members of the club at its first meeting in Milwaukee last year at the time of the society's annual meeting.

The doctors honored were R. C. Faulds, Abrams; Thos. Arneson, Almena; M. J. Donohue, Antigo; E. H. Brooks and J. S. Reeve, Appleton; J. M. Dodd, Ashland; H. J. Irwin, Baraboo; C. C. Post, Barron; W. W. Crockett, Beloit; Mina B. Glasier, Bloomington; C. S. Hayman, Boscobel; L. A. Van Altena, Cedar Grove; E. A. Miller, Clintonville; Wm. Reese, Dodgeville;

W. R. Notbohm, Dousman; J. J. Fitzgerald, Eagle; T. H. Marsden, Fennimore; W. H. Folsom and D. V. Meiklejohn, Fond du Lac; H. O. Caswell, Ft. Atkinson; H. A. Jegi, Galesville; L. H. Baldwin, Gillett; R. C. Buchanan, Green Bay; E. A. Petzke, Hixton; P. A. Panetti, Hustisford; T. W. Nuzum; Janesville; C. D. Boyd, Kaukauna; R. C. Montgomery, King; J. H. Doyle, Little Chute; F. F. Bowman and C. A. Harper, Madison; F. W. Hammond, Manitowoc; E. W. Burkhardt, Menomonee Falls;

E. P. Webb, Beaver Dam; G. E. Crosley, Milton; J. S. Barnes, A. M. Bodden, August Doerr, G. H. Fellman, Wm. Fitzgibbon, A. R. F. Grob, V. A. Gudex, G. A. Hipke, A. T. Holbrook, Joseph Kahn, O. E. Lademan, A. J. Patek and J. Gurney Taylor, Milwaukee;

T. G. Torpy, Minocqua; G. H. Williamson, Neenah; F. J. Donnelly, North Lake; M. R. Wilkinson, Oconomowoc; G. C. Devine, Ontario; F. G. Connell, Oshkosh; Alfred Belitz, Pepin; Wilson Cunningham, Platteville; C. K. Hahn and W. C. Hanson, Racine; E. C. Barnes, Ripon; C. T. Tasche, Sheboygan; W. A. Sickles, So. Milwaukee (deceased), S. D. Beebe, Sparta; H. E. Perrin, Star Prairie; L. W. Beebe and W. E. Ground, Superior;

R. W. McCracken, Union Grove; R. E. Davies, E. C. Grosskopf and U. J. Tibbits, Waukesha; H. E. Breckenridge, Waupaca; G. L. Karnopp, Wautoma; Arnold Drexel, Wauwatosa, and J. J. Looze, Wisconsin Rapids.

Date of First Treatment Must Be Reported on Form 100, Doran Reminds

Date Is Used as Starting Period of Authorization

Madison, June 1.—Physicians should be extremely careful to report on the Form 100 the date of the first treatment or examination given to the veteran, warns Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency. This is necessary because the earliest date on which either the doctor or patient signs the Form 100 will be used by the VA as the starting period of the authorization for treatment.

Mr. Doran pointed out that there are two places on the Form 100 on which dates should appear. The first is item 7 at the end of the part to be filled in by the veteran. The second is the last line of the part to be filled in by the doctor. Because the earliest of these two dates will be used as the starting period of treatment, the doctor should always write in the date of the first treatment or examination. Only by this procedure can the doctor be assured that the authorization will reimburse him for the first treatment.

Hospital Plan—

(Continued from page 1)

ease beds at Madison and 500 psychopathic beds at Oshkosh.

The revised priority schedule for allocation of federal funds to Wisconsin for the fiscal year 1948–49 is as follows:

COMMUNITY	PRIORITY	BEDS
Hayward	A–1	36
Chilton	A–2	66
Tomah	A–3	58
New Richmond*	A–4	55
Ft. Atkinson*	A–5	82
Darlington*	A–6	47
Viroqua*	A–7	78
Clintonville*	A–8	64
Stanley	A–9	62
Lancaster	A–10	66
Kewaunee	A–11	27
Algoma	A–11	27
Menomonie	A–12	89
Spooner	A–13	38
Neillsville	A–14	43
Park Falls	A–15	55
Mauston	A–16	55
Whitehall	A–17	45
Platteville	A–18	60
Prairie du Chlen	A–19	38
Dodgeville	A–20	51
Amery	A–21	30
Osceola	A–21	10
Burlington	A–22	57
Friendship	A–23	26
Berlin	A–24	37
Wautoma	A–24	15
Richland Center	B–25	81
Boscobel	B–25	40
Waukesha	B–26	184
Ashland	B–27	113
Sturgeon Bay	B–28	43
River Falls	B–29	31
Rhinelander	B–30	26
Crandon	B–30	15
Eagle River	B–30	15
Durand	B–31	35
Mondovi	B–31	0
Marinette	B–32	73
Florence	B-32	15
Watertown	B–33	55
Oconomowoc	B–33	40
Antigo	C–34	47
Green Bay	C–35	207
Wis. Rapids	C–36	60
Stevens Point	C–37	60
Portage	C–38	40
Frederic	C–39	23
Columbus	C–40	21
Rice Lake	C–41	46
Medford	C–42	24
Beaver Dam	C–43	38
Milwaukee	C–44	1477
So. Milwaukee	C–44	100
New London	C–45	0
Waupaca	C–45	38
Oconto	C–46	23
Shawano	C–47	29
State-wide Wis. Gen. Hosp.	C–47	300
Black River Falls	C–48	14
Reedsburg	C–49	14
Fond du Lac	C–50	44
Ripon	C–50	12
Waupun	C–50	40
Sparta	C–51	16
Manitowoc	C–52	30
Two Rivers	C–52	37
Elkhorn	C–53	25
Merrill	D–54	15
Madison	D–55	125
Stoughton	D–55	26
Superior	D–56	45
Oshkosh	D–57	47
Racine	D–58	102
Kenosha	D–58	0
Appleton	D–59	0
Neenah	D–59	0
Kaukauna	D–59	51
West Bend	D–60	0
Hartford	D–60	14
Port Washington	D–60	14
Arcadia	D–61	6
Baraboo	D–62	8
La Crosse	D–63	42
Sheboygan	D–64	0
Plymouth	D–64	24
Monroe	D–65	5
Tomahawk	D–66	1
Eau Claire	D–67	0
Chippewa Falls	D–67	0
Ladysmith	D–68	0
Janesville	D–69	0
Edgerton	D–69	0
Beloit	D–69	0
Wausau	D–70	0
Marshfield	D–71	0

* Grants approved for year ending June 30, 1948.

The new schedule also proposes city-county health units for Green Bay, Milwaukee, Fond du Lac, Madison, Oshkosh, Racine, Kenosha, La Crosse, Sheboygan, Eau Claire, Janesville and Wausau; county health units for Lancaster, Waukesha, Wis. Rapids, Beaver Dam, Superior, Appleton and Chippewa Falls; and multiple county health units for Ft. Atkinson, Algoma, Menomonie, Dodgeville, Richland Center, Ashland, River Falls, Rhinelander, Mondovi, Marinette, Antigo, Stevens Point, Portage, Frederic, Medford, Sparta, Manitowoc, West Bend, Baraboo and Ladysmith.

DOCTORS TO BILL ACCORDING TO NEW WISCONSIN PLAN

In Wisconsin, all physicians have been sent copies of the new schedule of benefits for The Wisconsin Plan. This schedule will immediately apply for all policies effective after May 31. Policies in effect prior to May 31 will come under the new schedule of benefits upon the anniversary date of the policy.

Physicians are advised to bill all Wisconsin Plan patients under the new schedule of benefits since it is impossible for the doctor to know which policies are new or old. Should any question arise between physicians and insurance companies concerning the schedule of benefits, the committee of seven physicians will be pleased to take up the matter for consideration, according to Dr. H. H. Christoffer-son, chairman.

County Society Officers Meet in Chicago June 20

Chicago, May 15.—The Third National Conference of County Medical Society Officers will be held on June 20 at the Palmer House in Chicago as part of the American Medical Association annual convention June 21–25, it was announced by Dr. A. M. Mitchell, Terre Haute, Ind., chairman of the conference.

Societies' Duties

The purpose of the meeting is to develop a working partnership between the American Medical Association and every physician. The program will be devoted to the part of the county medical society in medical organization and the county medical society's responsibility to membership and the public.

A MOMENT OF FORETHOUGHT

Doctors taught the world that *an ounce of prevention is worth a pound of cure.*

Insurance could well rephrase this to be *a moment of forethought is worth years of regret.*

Don't risk being without proper disability insurance. Take a few moments now to be sure your plan of protection is adequate. Your local TIME agent can offer valuable assistance.

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Industrial Health Clinics Attract 565 Delegates

Madison, June 1.—More than 565 representatives of medicine, nursing and plant management, among them 259 physicians, attended the 1948 series of industrial health clinics sponsored by the state and county medical societies in conjunction with the industrial hygiene unit of the State Board of Health, reports Dr. D. E. Dorchester, Sturgeon Bay, chairman of the state society's Committee on Industrial Health.

The clinics were held April 15 at the Lakeview Paper Mill, Neenah; March 31 at Fairbanks–Morse Mfg. Co., Beloit; April 21 at the Massey–Harris Company, Racine and on May 6 at the Gisholt Machine Co., Madison.

Four Clinics

Each of the clinics was designed to acquaint those who attended with the hazards facing industrial workers and to seek methods of eliminating or reducing the industrial accident and disease rate.

Dr. Paul A. Brehm, director of the industrial hygiene unit of the State Board of Health, and Mr. Harry Nelson, director of the workmen's compensation division, State Industrial Commission, spoke at all meetings. The Beloit clinic included a tour of the Fairbanks–Morse plant to view the brass foundry and welding and spraying operations with special attention to toxic fumes and dusts. Dr. E. L. Belknap, Milwaukee, medical consultant for Globe Union Mfg. Co., discussed this field.

At Neenah the plant tour covered the conversion of pulp into tissue and the mechanized processes in the manufacture of "Kotex" and "Kleenex." Speakers there included Henry Boon, vice president; Al Johnson, chief safety engineer, and Dr. J. B. MacLaren, medical director, all of Kimberly Clark Corp., and John Arnold, president of the Neenah–Menasha Trades and Labor Council.

Industrial processes are viewed by a group of physicians attending the industrial health clinic at the Massey–Harris Co. plant at Racine, April 21. A total of 196 doctors, nurses and plant managers attended this clinic.

The Racine meeting emphasized control of dermatitis in use of cutting oils and paint spray toxic agents with Dr. Victor G. Heiser, author of "American Doctor's Odyssey," Dr. John Hitz, Milwaukee; Dr. Harvey S. Allen, Northwestern University, and Dr. J. Daniel Willems, Chicago, as speakers.

The Gisholt Machine Co. tour in Madison paid special attention to controls against toxic fumes and dusts and safety measures in the iron foundry. Dr. O. A. Sander, Milwaukee, silicosis expert, addressed the physicians.

The value of these clinics was emphasized by an editorial statement of the Beloit *News* on March 25:

"The clinic to be held here, one of several planned in the state, should be of inestimable value to everyone concerned. There is only one way to lick accidents and sickness and that is to keep everlastingly at preventive measures."

Dr. Dorchester reports that the clinics attracted the attention of management more than ever before, and that these programs are a means of demonstrating that medicine "has the will as well as the skill to render superlatively fine medical care to the workers of Wisconsin."

The Neenah–Appleton Industrial Health Clinic . . . (l. to r.) at the speakers' table are: Henry Boon, vice president, Kimberly–Clark; Harry Nelson, director, Workmen's Compensation Division, Madison; Dr. T. D. Smith, Neenah; John Arnold, president, Neenah–Menasha Trades and Labor Council; Dr. J. B. McLaren, Appleton; Dr. A. M. Bachhuber, Kaukauna, and Mr. C. H. Crownhart, Madison.

ALCOHOLISM IS NO JOKE—NEED HELP OF DOCTORS TO MAKE CONTROLS WORK

By WALTER O. CROMWELL, Director, Bureau of Alcohol Studies

The party inebriate is the center of laughter. The town drunkard is the object of sly joking. But alcoholism isn't funny. Alcoholism is a serious social and public health problem.

Alcohol's intoxicating properties and its power to enslave certain types of persons brings about excessive indulgence and subsequent physical, mental and social deterioration. Alcoholism has serious consequences, not only for the individual victim but for his family and the entire community. About 80 percent of the alcoholics are between 30 and 55 years of age—they are persons from every walk of life and every segment of the population; they are at the age of greatest potential as contributors to the industrial, political, educational, religious and social life of the community; they constitute a serious loss and a tremendous burden to society. Alcoholism is not a temporary thing—it remains with an individual for the rest of his life unless he is rehabilitated.

The State of Wisconsin has recognized the impact of alcoholism and inebriety on its citizens. In 1947 a law was enacted creating the Bureau of Alcohol Studies with the treatment, control and prevention of alcoholism as its objectives.

To achieve these objectives the Bureau will cooperate with state, county and local government agencies, with public and private groups and interested individuals; promote, conduct and finance studies and research concerning the causes, extent, prevention, control and treatment of alcoholics; promote establishment of treatment and rehabilitation facilities; establish standards for treatment and rehabilitation and give financial aid to counties and towns to provide proper treatment facilities.

But it takes more than a law to get results. The success of the project will depend largely on the interest and cooperation of public and private health and welfare groups, medical men, churches, civic and business organizations, associations, institutions and all the agencies of government which come in contact with the alcoholic. It will take the teamwork of the entire community.

Medical men and medical facilities will of necessity play a major role in the solution of the problem. Doctors in private practice have a singularly outstanding role because of their firsthand acquaintance with the problems, both personal and social, of those involved in alcoholism. Special doctors and psychiatrists should be trained in alcoholism. Medical and scientific groups will be called upon to help establish new facilities and standards for treatment. Clinics are needed for diagnosis and treatment. Doctors can aid immeasurably in the tremendous program of public education that is needed. Hospital beds are needed for alcoholics. Research into the causes of alcoholism ought to be conducted in medical schools and hospitals.

The Wisconsin legislature took the first step toward intelligent solution of the alcoholism problem. The next step is more difficult—the organization and direction of coordinated programs of education, treatment and research. What is being done?

There has been an encouraging upsurge of interest as the result of a recent conference on alcoholism held in Madison. Since then Green Bay, Eau Claire and Chippewa Falls have taken steps to organize alcoholic treatment facilities. Green Bay has invited 17 persons from every profession and walk of life to serve on an alcoholism committee. The Milwaukee County Board has approved an outpatient clinic and is ready to go when it gets the staff.

All over the state, civic and private groups are whetting their interest in the problem. But this difficult and pioneering task is only beginning. The State Bureau of Alcohol Studies seeks to establish the closest possible team-work with all interested groups and individuals. The physician is a tremendously important cog in the wheel.

For doctor, clergy, farmer, lawyer, policeman, and common laborer the problem is the same—education. At this stage, there is but one major goal—to sell the Wisconsin public on the fact that the alcoholic is a sick person, that he can be helped and that he is worth helping.

Army Syphilis Records Available to Doctors

Must Get Vet's Permission

Washington, D. C., June 7.—Resumes of the syphilis records of Army and other personnel are in the custody of the VA and are now available to physicians treating such persons provided authorization for the release of the data is given by the veteran, Dr. Paul B. Magnuson, chief medical director of the VA, has announced.

Dr. Magnuson suggests that many physicians treating veterans for syphilis as private patients would find a resume of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

Requests for the resumes accompanied by an authorization for release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. The veteran's service serial number, date of enlistment, date of discharge, rank and organization should be included.

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Vivisection Needed to Save Lives, Bring Medical Advances, Doctor Says

Dr. Christensen Gives Facts Before Wausau Audience

Wausau, April 20.—The important role of vivisection in the development of drugs and surgical methods for the saving of human lives was stressed by Dr. H. H. Christensen, Wausau, in a talk before members of the Rotary Club on April 19.

"I will present the facts and allow you to judge if there is need for experimentation on living animals," Dr. Christensen declared.

Pointing to the raising and slaying of animals for food and clothing, he asked, "Isn't it also right to use animals to dispel diseases?" The question, he asserted, is whether or not it is right for a higher form of life to live on a lower form of life.

Referring to the famous old painting of the doctor bending over a sick child, Dr. Christensen said, "I know and every doctor knows how he felt. We know he was wishing and praying for a miracle. But we know the miracle must be sought through science."

But advances in medical science cannot be made in a dead test tube, the speaker said. It requires living cells, he declared.

Getting down to specific instances of the usefulness of animals in medicine, he told how insulin was discovered in 1921 by the tying of the duct from the pancreas in dogs, thus isolating the diabetic control factor. "Even today," he said, "each batch of insulin must be tested in dogs."

The famed sulfa drugs were nearly stumbled on in 1908, Dr. Christensen revealed, but it was a quarter century later before the value of the drugs in fighting blood poison was discovered by experimentation with the drugs in thousands of mice.

Many doctors, including himself, had noted how molds killed bacteria, Dr. Christensen said. But it was only through experimentation with rats, cats and mice that doctors finally discovered that penicillin would kill bacteria in human beings and learned how much penicillin should be administered.

"All living cells are similar in many ways," Dr. Christensen said. "That is why animals can successfully be used in experimentation." He told how man's best friend, the dog, was used to experiment on penicillin's use in appendicitis and peritonitis cases.

Co-op Plan—

(Continued from page 1)

ward bed is not available; board of patient and regular floor nurse service; use of operating and delivery room and salaried hospital anesthetist; dressings and drugs ($25 limit on drugs) as stocked by the hospital; clinical and pathological laboratory services and x-ray services as done by employees of the hospital; serums, intravenous solutions, liver extracts, glandular products, as stocked by hospital, and electrocardiograms, basal metabolism studies, physical and oxygen therapy.

Outpatient hospital benefits include clinical and pathological services, and x-ray services as done by salaried employees of hospital and electrocardiograms, basal metabolism studies, physical and oxygen therapy.

Medical benefits include "complete physical examination, regular office calls and treatments, emergency house calls at extra cost, obstetrical care including prenatal and postnatal examinations, all surgery as can be performed by contracting doctors, specialist consultation with any staff doctor, administration of vaccines, antitoxins and sera, and such other medical services as are within the ability of staff doctors to render."

The schedule also provides for emergency benefits away from the health center for "any member requiring them . . . . . in any licensed hospital or with any licensed doctor in the world, for services ordinarily covered at the Waushara County Cooperative Health Association." They include allowance toward board and room charges in hospital of $4 per day for not more than 30 days in any one year; miscellaneous services not to exceed $20 and the "cost of medical and surgical treatment not to exceed $100 per year for accidental injuries or acute illnesses rendered outside this hospital area."

No benefits will be paid for pregnancy which terminates within the first 10 months of membership, except to charter members who are covered immediately. No benefits are paid for "elective surgery within the first 12 months of membership, except charter members, who are covered immediately, and then only at the discretion of the attending physician." There is a limitation of $25 on drugs.

In addition to the usual exclusions of workmen's compensation and veterans cases the Waushara plan excludes benefits for "surgery of the brain and nervous system, plastic surgery, correction of deformities and birthmarks, surgery of the lungs, heart and intrathoracic organs, dental care, and psychiatric treatment or consultation."

Form 200 Can Be Used to Get More Treatment Than First Authorized

Agency Must Receive Form Within 15 Days

Madison, May 28.—A physician may now receive authorization for rendering more treatment than was originally authorized simply by indicating the additional treatment on Wisconsin Veterans Medical Service Agency Form 200 and getting that form to the Agency office within 15 days after the treatment was rendered, Mr. T. J. Doran, director of the Agency, said.

Instructions received from the VA medical director state:

"When it is indicated on the Wisconsin Veterans Medical Service Agency Form 200 that the doctor has rendered and is claiming reimbursement for more treatment than was originally authorized, the 15-day notification will apply as for emergency out-patient treatment. If Form 200 indicates treatments in excess of those authorized, all such treatments which are shown to have been given within 15 days of the date of receipt of Form 200 (in the Agency office) may be authorized. All such additional treatment indicated as having been given more than 15 days prior to date of receipt in the office will be denied on the basis of delinquent notification."

If four office calls had been authorized originally, and in the medical judgment of the physician, two extra office calls and one home call were needed, the notice of that extra treatment must be received on the Form 200 in the Agency office within 15 days after that extra treatment was given.

Public Relations Is Service and Understanding, Doctors Are Told at Secretaries' Conferences

Madison, June 4.—Good public relations between the medical profession and the public depend upon the fact that the doctor and the public understand each other and that the doctors meet the real needs of the public for medical care, declared Mr. John Bach, Chicago, director of press relations for the American Medical Association, in a talk at the first annual series of "Secretaries' Conferences" sponsored by the Council on Medical Service and Public Relations of the State Medical Society.

The conferences were held May 26–27 in Fond du Lac and Baraboo and June 2–3 in Wausau and Rice Lake. They are part of the Council's effort to bring physicians into closer acquaintance with society activities and medical economic and public relations problems.

Mr. Bach declared that medical public relations problems have multiplied a thousand fold since the passing of the horse and buggy doctor. He said every physician is in public relations. "Public relations in the field of medicine is nothing more than mutual understanding, respect and sometimes affection. It is the warm handclasp which you give to every patient you meet—the ready, sincere smile. It is a high and continuing regard for the other fellow—your patient."

Public relations is not the kind of magic that comes from "putting pieces and pictures about yourselves in the newspapers and having radio commentators and other publicists say nice things about you," Mr. Bach warned the doctors, although he added that the newspaper has an effective place as one of the many devices for creating public interest, understanding and good will.

At the Fond du Lac and Baraboo meetings, Mr. Lawrence W. Rember, executive assistant of the American Medical Association, gave emphasis to the importance of doctors dealing with their special publics, some of which are the patients, channels of communication, general public, health groups, civic groups and legislators. He declared that "we will be derelict in our duty and our opportunities if we do not institute all-around good public relations programs on the county, state and national basis."

Dr. E. B. Howard.

Dr. Ernest Howard Joins AMA Staff

Is Assistant Secretary

Chicago, May 15.—The American Medical Association recently announced the appointment of Dr. Ernest B. Howard as assistant secretary of the Association. He began his duties on April 1.

Doctor Howard is a graduate of Harvard University and received his M. D. degree from Boston University School of Medicine in 1936.

From 1946 to 1948 he was chief of the health mission to Peru sponsored by the Institute of Inter-American Affairs of the U. S. Department of State.

Dr. W. D. Stovall, president of the State Medical Society, and Dr. K. H. Doege, president-elect, strongly urged that county society officers become more acquainted with their state society and take advantage of what it offers in the way of information, training and leadership. They emphasized the need for every doctor to explain to his patients and the people of his community the reasons for medicine's opposition to socialized medicine.

Mr. Fred Mott, of the Wisconsin State Department of Veterans Affairs, and Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency of the State Medical Society, explained the relation of the doctor to the state and federal agencies which operate to provide medical care for veterans.

Dr. C. N. Neupert, state health officer, clarified the difference between public health and preventive medicine and urged county medical societies to support county, city-county and multiple county health units as a means of bettering the health of the state. Mr. C. H. Crownhart, secretary of the State Medical Society, called attention to the "organized efforts of many federal agencies and employees" in promoting socialized medicine, and outlined the wide scope of activities of the state society.

Don't Wait Until Last Day to Send in WVMSA Forms

15 Day Limit for Outpatient Forms; 72 Hour Limit on Emergency Hospitalization

Madison, June 7.—Don't wait until the fifteen day time limit has nearly elapsed before requesting authorization for out-patient treatment of veterans, Mr. T. J. Doran, director of Wisconsin Veterans Medical Service Agency, requests of the state's doctors. He urges that doctors submit their requests (Form 100) as soon as the veteran reports for treatment. It is equally important, he said, that the doctor report the date of the first treatment given the veteran.

The VA specifies that Form 100 must reach the Agency within 15 days after the first treatment or examination is given to the veteran. Too often the form is held by the doctor until the deadline is so close that the mails are not able to get it into the Agency office before the 15 days has elapsed. The starting date of the authority can be backdated only 15 days and as a result the doctor may not receive authority for the first treatment.

The same situation is true with regard to emergency hospitalization, Mr. Doran stated. Authorization for hospitalization should be requested immediately after the veteran enters the hospital, and not at the end of the 72 hour time limit for notification as set up by the VA regulations.

KEEP MEDICINE FREE: STASSEN

Pledges Support of Medicine

Minneapolis, June 9.—No action affecting the medical profession or health should ever be taken by government unless it is approved by the medical profession as it acts through organized medicine, declared Minnesota's Gov. Harold E. Stassen at the annual meeting of the House of Delegates of the Minnesota Medical Association.

In answer to critics who have challenged his support of medicine, Gov. Stassen said, "I am against compulsory health insurance, the Wagner–Murray–Dingell bill. Socialized medicine I have always been against and will continue to be against it."

Reaffirming his stand, Stassen declared, "If I do become President of the United States there will never be a law that becomes an act with my signature that affects medicine or health in this country that is not approved by the medical profession of America."

He stated that "American medicine is the best in the world; that it is best because it has been free. I am opposed to the government going into medicine. I am opposed to government in any way making a profession, such as the medical profession, subordinate to it in any manner. I feel that there has been ample evidence in Europe of the shortcomings and failures that develop when government attempts to take over, whether it is in medicine or some of the other activities that the socialized governments have endeavored to approach."

Stassen praised Minnesota medical men and medicine for its rapid progress, and announced that Dr. Ralph P. Sproule, Milwaukee, a Stassen delegate, will be his spokesman on all matters of medicine or health in the Republican platform at the Republican National Convention in Philadelphia.

DOCTOR DRAFT BILL GETS PAST SENATE

Expect Fight in House

Washington, D. C., June 7.—The Senate has passed the Selective Service bill calling for the induction of persons between 19 and 25 years of age and a special draft of physicians up to 45 years of age. The bill is now being considered by the House.

Terming this legislation the "most important piece of legislation before the Senate and the House of Representatives from medicine's point of view at this time," Dr. Joseph S. Lawrence, director of the Washington office of the American Medical Association, declared that the bill may yet be "extensively and probably bitterly debated."

Gov. Warren Urges Compulsory Medicine for California

Gov. Earl Warren of California writes in the June 22 issue of *Look* how he proposes to make that state the first in the nation to "banish the ruinous cost of serious illness" by means of a plan that would require all employees to pay one per cent of their income up to $3,000 a year into a health service fund.

Governor Warren argues for his health insurance plan on the basis of humanitarian need. Pointing to the "bankruptcy, tragedy and loss of self-reliance" that illness brings to families without insurance, he declared that the problem is one of "tragic human need versus long-reaching fear of foreign ideologies, and the knife-sharp theories of experts." Warren declares that his plan specifically prohibits state medicine.

In his article, Warren admits that families stricken with catastrophic sickness would have been "all right" if they had shown "the foresight to subscribe to a voluntary health insurance plan." He added that "the hard fact is that they don't have such foresight," and therefore a plan is needed that will help "families of moderate income to have the means and the foresight to protect themselves against the tragic consequences of unexpected serious illness."

Under Warren's plan, the employer would match the contribution of the employee to the health service fund. He claims that the doctor-patient-hospital relationship will be undisturbed and the plan will use the fee-for-service method of payment. Contributors to the fund will be assured "payment in full of the costs of hospital and laboratory services, with certain reasonable restrictions, and the costs of medical care in hospital cases" for themselves and their families.

Compulsory Medicine No Good, Dewey Says

Talks to Oregon Doctors

Portland, Ore., May 1.—Compulsory medical care is unworkable, would bankrupt our society and destroy the standard of medical care in our nation and would be the greatest catastrophe in the United States, Governor Thomas E. Dewey, declared in an address before the House of Delegates of the Oregon State Medical Society today.

Governor Dewey based these remarks on the results of an 18-month investigation of compulsory plans in Saskatchewan, New Zealand, Germany and Los Angeles carried out at the request of the New York state legislature.

He pointed out that his state spent more than $200,000 to find out that experience with the Saskatchewan, New Zealand and Australian programs proves that "every time they tried to compel people to pay a certain sum to government for medical care they destroyed the medical care they were to receive."

"Compulsory, socialized medicine is no good," he declared, "It cannot be done. Accordingly I have spent the last two years knocking down every proposal that anybody has made to regiment the medical profession and the people of America through any program of socialized medicine."

"I don't want to run the risk of having happen to the health of our people what has happened to the health of every group of people when they have tried to drag the medical profession down to the Socialist's level. You won't drag anything up. You will enlarge the volume of medical care but utterly destroy the quality of medical care the minute you try that process."

Governor Dewey said the idea that medical care can be improved by passing a law must be stopped. He urged a "vast educational program for the people as to the quality of care that now exists and the greater program that is now going forward under men of medicine."

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

E. A. BIRGE, II

Doctor Birge, who is now director of the laboratory at Milwaukee Hospital, received his medical degree from Johns Hopkins University School of Medicine in 1936. In 1938 he joined the staff of the University of Wisconsin Medical School as an instructor in clinical pathology. Following service with the Army Medical Corps from 1942 to 1945, he returned to the staff of the university as assistant professor of clinical pathology. He has served in his present position since early in 1947.

Serologic Tests For Syphilis

Serologic tests are now well established methods for the detection of syphilis. The test has become so valuable and is so widely used that often one forgets that it is not a specific or infallible method of diagnosis. Fundamentally, the test consists of the use of an artificial nonspecific antigen, beefheart, which is handled in such a way that it can be used for the diagnosis of a specific disease. A large number of tests have been devised, each of which strives to achieve the goal of absolute specificity with maximal sensitivity. In the hand of its creator, each of the standard tests comes close to this goal but still does not quite achieve it. The sensitivity and the specificity of these tests are altered by minor changes in technic. Therefore, any person who may be responsible for laboratory procedures should see that any serologic test for syphilis is performed exactly as devised by its creator. Alterations in technic are not *allowable* unless such changes have been carefully checked against a large series of routine serum samples from patients whose clinical history is known.

In 1941 Pangborn isolated a phospholipid from heart muscle which seems to contain all of the active antigenic principle. This material, when combined with lecithin and cholesterol, can be used as a diagnostic antigen. By using these components, which are pure chemicals, one would expect that a more specific and sensitive test for syphilis could be devised to replace the multiple battery of tests which are now in use. Unfortunately, up until the present time, each prominent serologist has used this new antigenic substance as a substitute for his own antigen in the test of his own devising. As a result of this, one finds that instead of the number of tests for syphilis decreasing, they have actually doubled. Needless to say, tests with the Pangborn antigen are still in the experimental stage, and the final results cannot yet be evaluated. Nevertheless, the early preliminary reports are favorable, and it would seem that the new test will be more specific and as sensitive as any of the tests which are now in general use. It must be emphasized for the enthusiast, however, that tests with the Pangborn antigen are not 100 per cent specific, as an occasional false positive is still reported. The goal of a test which is absolutely specific is probably a utopia which cannot be achieved. It certainly has not been achieved by any of the serologic tests used for the diagnosis of other diseases. The more bacteria are studied, the more evident it becomes that each bacterium is composed, not of a single antigen, but of multiple antigens, and many of these antigens are found widely distributed through the bacterial kingdom. Accordingly, cross reactions, at least in a small percentage of cases, must be expected.

Interpretations of the results of a serologic test must be made only in the light of the findings obtained from a careful history and physical examination of the patient. Both false negative and false positive results may occur. False negative results are usually found when the disease is quite early or as a result of technical errors in the laboratory.

False positive results appear to be more common, probably because they are easier to recognize clinically. These inaccuracies are quite rare when one considers them in relation to the population at large. However, from the point of view of the individual patient, such an inaccurate result not only is extremely embarrassing but may lead to a needless course of potentially dangerous therapy.—EDWARD A. BIRGE, M. D.

(To be concluded next month)

WISCONSIN STATE MEDICAL GOLF ASSOCIATION TO MEET IN MADISON

The midsummer meeting of the Wisconsin State Medical Golfing Association will be held at the Maple Bluff Country Club in Madison on July 21. Dr. Albert Tormey, Madison, is in charge of arrangements for the event, and a good program is assured.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

E. H. JORRIS

Doctor Jorris, a 1930 graduate of the University of Minnesota Medical School, joined the Wisconsin State Department of Health in 1936 as a district health officer with headquarters at Sparta. Taking time out to gain an MSPH degree at Michigan in 1940, he returned to the department as supervisor of local health services and director of the tuberculosis division. He served in the Naval Reserve (MC) in World War II, attained the rank of commander, and returned to the department in 1946 as assistant state health officer.

Communicable Disease Units in General Hospitals

The isolation hospital, unless it serves a large center of population, has become an anachronism. Originating in the dark ages, its purpose was limited to isolation, and there was little consideration for treatment of the patient. Centuries later, after the discovery and identification of specific disease organisms and the growth of knowledge on medical therapeutics, treatment of communicable disease in the existing isolation hospitals followed as a natural corollary.

The Wisconsin Situation

In Wisconsin a review of our concepts of the need for separate isolation hospitals for the treatment of communicable diseases seems to be in order at this time, as many communities are planning for the construction of additional hospital facilities.

In Wisconsin the control of such diseases as diphtheria, smallpox, typhoid fever, and other maladies having grave communicable aspects has reduced the use of isolation hospitals in our middle-sized cities to an extent which causes the city fathers to question their continued existence. The seasonal character of communicable disease makes it difficult, if not impossible, to keep a staff on duty in proportion to the need. In any community short of a large metropolis an isolation hospital is probably economically unsound.

Isolation Wings as a Solution

While it is true that hospitalization of certain communicable diseases is still necessary, it is not true that it must be effected in a separate building. An isolation wing or unit of a general hospital, properly designed and properly operated with reference to its purpose, is the answer to this problem in the middle-sized or small city.

When the isolation unit is incorporated as a part of a general hospital, it not only makes possible municipal economy, but greatly improves the services available to the patient. Consultation in the medical specialties, special nursing care, laboratory, and other facilities of the general hospital can be called upon whenever needed. Our present knowledge of disinfection and isolation technics permits professional care in general hospitals without danger of cross-infection. The diagnosis and treatment of complications common to the various communicable diseases by specialists in their fields constitute an especially important reason why an isolation unit of a general hospital is more desirable than a separate isolation hospital.

Then, too, the fear complex of a large segment of the public obtains as a hand-me-down from past generations, and it attaches to the isolation hospital a stigma which tends to depress the patient. This complex is far less in evidence when the isolation is effected in a unit of a general hospital.

Granted that Milwaukee and perhaps one or two other Wisconsin cities are in a position to operate separate isolation hospitals, it remains true that many of our other population centers need hospital facilities for the care of communicable diseases.

These can be economically provided through isolation units of general hospitals. Every community which contemplates expansion of its hospital facilities should include plans for an isolation unit in its general hospital of a size commensurate with its needs.—E. H. JORRIS, M. D., *Assistant State Health Officer.*

PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected reregistration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana, write immediately to the office of the Collector of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect reregistration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

. . . . THE PRESIDENT'S PAGE . . . .

Individualism

OUR time is characterized by confidence in group action. Not only is the group thought to be essential to the welfare of the individual, but, what is more important, the welfare of the group is thought by some to be paramount to that of the individual. We speak of public welfare, public health, and *the public*, as if the word "public" designates an animated individual organism having a significance over and above the individuals who compose it. The individual in the group, in some instances anyway, has been lost sight of in this glorification or spiritualizing of the group as a whole.

There is great danger in the overemphasis of the group, because it is easily turned into a religious kind of fervor by false leaders, man's salvation of man. When this happens the welfare of the individual man is lost in his subjugation to the rules and regulations promulgated for the group. It is true that the orders are issued in an atmosphere of freedom and liberty, but they have the effect of edicts. Individual members dare not fail to conform. Failure means persecution, intimidation, and often punishment of a fanatical sort which is used to keep the group in line and the individual subservient.

The philosophy of managed welfare and group control is demonstrated throughout our social order. Its frequent effect is the creation of pressure groups. Here the individual is lost in the pressure of group or organizational effort. Under the guise of promoting individual welfare, groups contend among themselves over issues in which the individuals of the group have mutual interests. In these struggles the individual loses his identity and the resulting turmoil is a cauldron of fury heated by the contending forces of powerful interests. No matter which group wins, the individual as the basic unit of our social order is forgotten.

The relationship of the individual to groups and groups to the individual in society may aptly be compared to the individual cells of the human body and the body as a whole. The cell is the ultimate element in life, and the summation of the actions of all of the cells constitutes human physiology; so the individual man is the vital force in any social order, and the summation of his actions constitutes the physiology of society.

Systematized action of these units is often essential for the accomplishment of better social physiology; however, the establishment of a function for one group which is inimicable to the functions of another or the creation of a function for a group which is inimicable to the individuals within the group results in a pathologic function which may be termed pathologic physiology of society.

The doctor and the medical student can easily comprehend this simile between human physiology and human disease, between social function and social disease. The relationship of the similarity is intensified when the past is projected into the present so that the two, present and past, can be viewed together. In this way we see the two—early medical science and medical practice, modern medical science and modern practice—standing side by side. The latter has introduced new concepts and technics into our thinking, the control and prevention of disease, which are accomplished by environmental sanitation and the specific treatment of the individual. The doctor functions in the latter field and the sanitary engineer in the former.

Much progress in human welfare has been, and can be accomplished by systematized community action in the application of these technics. However, this success has given encouragement to some to believe that the answers to all public welfare problems can be found by this method of action. The fact is that in some instances it is not applicable without the loss of identity and dignity of the individual. Pressure groups have developed which have resulted in pathologic social function. This has threatened the dignity and freedom of the individual in some parts of the world and a loss of it in others.

Because the individual is the ultimate unit of our society toward whom all of the practices for the improvement of human welfare are directed and because the welfare of the individual determines, in the last analysis, the welfare of the group, it behooves us in planning social welfare to keep focused on him.

W. D. Stovall

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« « « EDITORIAL » » »

Introducing the Guest Editorialist

The guest editorial in this issue was written by a man who gained professional distinction among his contemporaries and has been awarded high honors by professional societies for the skill and devotion with which he performed the "every-day" services that constitute the medical practice of a rural physician.

"Every-day" service is used as an expression of the problems that patients and the families of patients bring to the physician. They are commonplace occurrences in his practice and for that reason do not generate an atmosphere of romance and glamour. Because these qualities are absent or have not been recognized except by a few, the life of the general practitioner has been regarded in some quarters as a rather humdrum performance of small medical services involving minor responsibilities. Our editorialist was one of the few who, recognizing the importance to people in rural areas of good medical service, was satisfied to become a rural practitioner. As a young man following his graduation in medicine and before launching into a career of teaching and research which was already marked out for him, he sought rest and recreation on a fishing trip which took him to a small mountain village in Colorado. What he saw there cleared his vision for what was important to him in the field of medicine. He decided that the people living in this mountainous area needed the kind of service he could render more than the world needed the discoveries he might make pursuing a life of research or the knowledge he might impart to students as a teacher. He gave up a hospital research and teaching position, left the metropolis and moved to Kremling, Colorado, where he practiced alone for twenty-one years administering to the medical needs and otherwise promoting the health of people residing in that area.

In recognition of the exceptional medical service which he rendered and also of the importance of rural medical practice, he was made president of the Colorado State Medical Society in 1946 and last year he was the recipient of the American Medical Association's first gold medal award to a general practitioner who has rendered exceptional service to his community.—W. D. Stovall, M. D.

Good Health and Healthful Living

GOOD health and healthful living constitute a dynamic process with unlimited potentiality and opportunity for ever increasing abundance. The process depends, for its perpetuation and availability, upon many factors, one of which, knowledge, supersedes all others. It begins with the individual person in a community, and it concerns the individual first, then equally the next person, and increasing in numbers until a community entity is born. It is local in character, becoming more complex as different components are accumulated through various geographic regions, until the aggregate becomes a state.

Good health is tremendously influenced by local area economic patterns, social forces, and health knowledge. It embraces far more than the general public today realizes. Today's public concept of the problem of building and maintaining good health and healthful living seems to be that this is a problem to be solved entirely by the availability of such factors as sufficient well trained physicians and surgeons, nurses, dentists, and other well trained allied professional workers, and by adequate hospitals, health units, and health laws.

Certainly these factors are essential, especially well trained professional personnel and adequate hospitals, when it comes to alleviating the distress of illness once it occurs. They are of weighty importance, but they constitute only a part of providing good health.

Health laws and codes geared to meet the needs of a local area today may be useful adjuncts at the moment, but frequently need revision tomorrow. But, for them to be effective at all, good public health knowledge in the local areas is the first essential. Good health practices stem from good health knowledge, not from compulsion or restriction by laws. We can no more effectively legislate our bad health problems out of existence than we can effectively prevent cancer or heart disease by making it unlawful for a person to become afflicted with these diseases.

A locality reflects its health status as a variable, depending upon many factors. Most of these are economic factors, such as sufficient proper food for the individual, adequate healthful housing, healthful working conditions in industry, sanitary facilities in the community, and opportunity for employment and earning with provision for proper recreation time.

Equally important from the health view, if not of greater importance, is a sound public knowledge of good health practices. If the individuals of a local area have sufficient knowledge concerning preventable disease, the community can abolish many of our contagious and infectious diseases from the area. This could be reflected through communities up to the state level by the simple application of available measures existing in the component local areas.

If the great potential force for good health in existence today—namely, our knowledge of available methods to prevent disease—is to be utilized fully, it is essential that the present concept held by the individual (not just one person but all of the individuals in a local area) be enlarged so that his concept includes all of the factors which affect the health problem.

It is here that our most strenuous efforts should be directed. Yet, today it is a neglected field. Recent surveys of our universities and colleges have revealed that there are few indeed that even make a pretense at teaching the fundamentals of established health measures in their curriculum. Since preventive medicine can advance only as rapidly as public knowledge permits public adoption, American medicine should provide leadership in the establishment of proper courses in health teaching, so that properly educated instructors will be available to teach these essentials of health in every school of our nation, from the grass roots on up.

It is the youth of our nation today who will determine our national status tomorrow. Until such a time as our universities and colleges assume their proper obligations in this matter, medical societies—county, district, and state—must do the job. They should organize courses to be given to teachers while those teachers are currently in service. They could and should teach these basic fundamentals about maintenance of good health and healthful living, and soon they should be able to pass most of the teaching job on to the re-educated teachers themselves, the medical societies continuing to cooperate with them in directing such courses.

Good health education, especially rural health education, is every bit as essential as reading, 'riting, and 'rithmetic. It is a fourth R in education, long neglected and costly to the nation.

A. C. Sudan, M. D.

As It Looks From The American Society of Anesthesiologists

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

JOHN H. HUNT

John H. Hunt, after being graduated by the University of Wisconsin in 1931, attended Northwestern University Law School. Upon being admitted to the bar, he practiced law in Topeka, Kansas, until his entry in the Air Forces in 1942. After completion of his military service and early in the year 1947, Mr. Hunt became the first executive secretary of The American Society of Anesthesiologists. His headquarters are now in Chicago.

Today the anesthesiologists recognize their lack of numbers as the greatest problem of their specialty and are doing something about it!

Since ether was demonstrated to be a practical anesthetic agent more than a hundred years ago, knowledge of that and other anesthetic agents and technics has steadily broadened. Gradually, through study and scientific research, the early methods of administering an anesthetic have evolved into the art and science of anesthesiology.

Until the beginning of World War II, doctors of medicine devoting their entire labors to the administration of anesthetics and research in anesthesia were relatively few. The demand for professional anesthesia prior to that time was limited. With the advent of that war, and undoubtedly to a large extent because of it, the demand for the anesthesiologist increased to the extent that, in spite of increased training programs during the war years, but a fraction of that demand could be filled.

To meet this situation, the American Society of Anesthesiologists, until then a small group concentrated in the Eastern metropolitan centers, reorganized themselves. In so doing, they set up a democratic governing body with representatives selected locally from all parts of the United States, and dedicated the Society to the following purposes, among others:

". . . To encourage specialization in this field (Anesthesiology) and in other ways to make available to more people the benefits to be derived from the services of qualified anesthesiologists; to raise the standards of the specialty by fostering and encouraging research and scientific progress in anesthesiology, . . .; to protect the public against irresponsible and unqualified practitioners of anesthesiology; . . . and in all ways to develop and further the specialty of anesthesiology for the general elevation of the standards of medical practice."

To put these purposes into effect a number of steps have been taken. That the demand for anesthesiologists, not only for teaching and supervisory purposes, but also as clinicians, be met insofar as possible in all parts of the country, the Society has established a placement bureau which is available to all hospitals, medical schools, medical societies, and such other groups as may desire anesthesiologists or residents in anesthesiology. This service is maintained purely as a service, and no charges are made. However, realizing that at the present time there are not enough anesthesiologists to fill the demand and that there are many communities which are not large enough to support a full-time anesthesiologist, the Society has created The American College of Anesthesiologists to encourage doctors who devote more than half their time to anesthesia to become better trained in this field by offering them a fellowship in the College after having successfully completed comprehensive oral and written examinations.

Also, to meet the demand for the anesthesiologists, especially in the smaller communities, and as a temporary measure in the metropolitan centers, the Society has committed itself to a program to attract well trained physicians whose practice is such that they can devote a portion of their time to anesthesia, to take special training in that field so that professional anesthesia will be available in their area.

To make the latest scientific information in anesthesia available to all physicians, the Society publishes the journal *Anesthesiology* and sponsors approximately ten regional scientific meetings each year throughout the country. Neither subscriptions to *Anesthesiology* nor attendance at those scientific programs is limited to members of the Society, but are available to all doctors of medicine who are interested in the subject.

Finally, the Society is now in the process of forming component societies in the various states so that problems involving anesthesiology may be attacked on a local as well as a national level.

With this framework and those services established, the Society is anxious to assist all medical societies, hospitals, medical schools, surgeons, and physicians dealing with the anesthetized patient in all matters involving anesthesiology in order "to develop and further the specialty of Anesthesiology for the general elevation of the standards of medical practice."—JOHN H. HUNT, *Executive Secretary.*

★

2nd Preliminary Announcement

- GENERAL SCIENTIFIC SESSIONS . . . . . p. 611
- OBSTETRIC MANIKIN DEMONSTRATIONS . . p. 612
- CLINICAL CONFERENCES . . . . . p. 613
- SECTION MEETINGS . . . . . p. 615

[ROUND-TABLE ANNOUNCEMENTS WILL BE MAILED YOU IN JULY!]

★

OUR DISTINGUISHED DINNER SPEAKER

HAROLD CLAYTON UREY, Ph. D., D. Sc.

Distinguished Service Professor of Chemistry, University of Chicago

"SOCIAL IMPLICATIONS OF ATOMIC ENERGY"

Harold Clayton Urey, one of the world's foremost scientists in the field of atomic energy, was educated at the University of Montana (B. S.), and the University of California (Ph. D.). He has been identified with the science departments of the University of Montana, Johns Hopkins University, Columbia University, and the University of Chicago.

In addition to his teaching and research work, Professor Urey has served as editor of the *Journal of Chemical Physics*, is a director and vice president of the American–Scandinavian Foundation, and is a member of numerous scientific and other learned societies.

Many citations have been bestowed upon Professor Urey for his scientific achievements. In 1934 he was the recipient of the Willard Gibbs Medal and in the same year won the much coveted Nobel Prize for his contributions to scientific advancement in the field of chemistry.

Professor Urey is a brilliant speaker, and the State Medical Society is honored to have him as guest speaker at its 1948 annual scientific assembly.

* * *

The annual dinner will be preceded by the President's Reception, at which Professor Urey will be the honored guest.

The dinner will also mark the second annual meeting of the "50 Year Club," with new members properly honored for their membership in this select group of Wisconsin physicians.

E. R. SCHMIDT, M. D.
General Program Chairman

GENERAL SCIENTIFIC SESSIONS

MONDAY OCTOBER 4

9:00–11:00 a. m.: **Clinical Conferences**
See the following pages for program details. *Advance reservations are required,* so fill out form with round-table reservations if you wish to participate in one of these three conferences. Specify which you will attend and whether you need transportation if you will attend the conference at Milwaukee County Hospital or the conference at Veterans Hospital, Wood

2:30– 3:00 p. m.: **"Research Progress on the Common Cold":** NORMAN H. TOPPING, M. D., U. S. Public Health Service, National Institute of Health, Bethesda, Maryland, and adjunct professor of medicine, George Washington University School of Medicine; professorial lecturer, Georgetown University School of Medicine, Washington, D. C.

3:00– 3:30 p. m.: **"Carcinoma of the Lung":** EVARTS A. GRAHAM, M. D., professor of surgery, Washington University School of Medicine, St. Louis (lecture sponsored by Wisconsin Division of the American Cancer Society)

3:30– 4:00 p. m.: **RECESS TO VIEW EXHIBITS**

4:00– 4:15 p. m.: **"Rheumatic Fever — Its Early Diagnosis":** S. F. MORGAN, M. D., associate professor of pediatrics, Marquette University School of Medicine, Milwaukee

4:15– 4:30 p. m.: **"Rheumatic Fever — Its Treatment":** C. M. KURTZ, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

4:30– 5:00 p. m.: **"Emotional Aspects of Organic Diseases":** H. W. BROSIN, M. D., professor of psychiatry, University of Chicago, The School of Medicine, Chicago (lecture sponsored by the Mental Hygiene Division, State Board of Health)

TUESDAY OCTOBER 5

9:00– 9:20 a. m.: **"Treatment of Carcinoma of the Prostate Gland":** JAMES C. SARGENT, M. D., professor of urology, Marquette University School of Medicine, Milwaukee

9:20– 9:50 a. m.: **"The Place of Nutrition in Medical Practice":** JOHN B. YOUMANS, M. D., dean, University of Illinois College of Medicine, Chicago

9:50–10:10 a. m.: **"The Role of Isotopes in the Treatment of Thyroid Disease":** EDGAR S. GORDON, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

10:10–10:40 a. m.: **RECESS TO VIEW EXHIBITS**

10:40–11:00 a. m.: **"Iatrogenic Disease":** HUGH PAYNE GREELEY, M. D., department of internal medicine, Lahey Clinic, Boston

11:10–11:40 a. m.: **"A Clinical Science of Child Development":** ARNOLD GESELL, M. D., professor of child hygiene, Yale University School of Medicine, New Haven, Connecticut

2:30– 3:00 p. m.: **"Surgical Complications of Amebiasis":** MICHAEL E. DEBAKEY, M. D., associate professor of surgery, Tulane University of Louisiana School of Medicine, New Orleans

3:00– 3:30 p. m.: **"Arthritis of the Spine—Diagnosis and Management":** RICHARD H. FREYBERG, M. D., associate professor of clinical medicine, Cornell University Medical College, New York

3:30– 4:00 p. m.: **RECESS TO VIEW EXHIBITS**

4:00– 4:30 p. m.: **"Some Aspects of Treatment of Emotional Illness":** HARRY M. MURDOCK, assistant professor of psychiatry, University of Maryland School of Medicine, Baltimore (lecture presented under sponsorship of the Rogers Memorial as the Theresa Rogers Memorial Lecture on Psychiatry)

4:30– 5:00 p. m.: **"Office Gynecology":** JOSEPH L. BAER, M. D., Chicago

9:00– 9:20 a. m.: **"An Analysis of the Causes of Failures in Fractures of the Neck of the Femur"**: C. C. SCHNEIDER, M. D., Milwaukee

9:20– 9:40 a. m.: **"Changing Concepts in Bowel Surgery"**: A. C. GORDER, M. D., Milwaukee

9:40–10:10 a. m.: **"The Ulcer Problem"**: OWEN H. WANGENSTEEN, M. D., professor and chief, department of surgery, University of Minnesota Medical School, Minneapolis

10:10–10:40 a. m.: **RECESS TO VIEW EXHIBITS**

10:40–11:10 a. m.: **"Cancer of the Stomach"**: B. R. KIRKLIN, M. D., professor of radiology, Graduate School, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

11:10–11:40 a. m.: **"Treatment of Leukemia"**: CHARLES WATKINS, M. D., associate professor of medicine, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

WEDNESDAY OCTOBER 6

OBSTETRIC MANIKIN DEMONSTRATIONS

On each of the three days of the Annual Meeting one special luncheon will be set aside for a combination manikin demonstration and round-table discussion. The schedule will be as follows:

Monday, October 4: "Emotional Problems of Expectant Mothers": D. M. BRITTON, M. D., Madison

Tuesday, October 5: "Obstetric Case Problems": F. JACKSON STODDARD, M. D., Milwaukee

Wednesday, October 6: "The Evaluation of Labor": R. L. COWLES, M. D., Green Bay

In each instance the discussion leader will be prepared to answer questions on various phases of delivery with the use of instruments. In order to fulfill the demand for this type of luncheon, the attendance for each of these three meetings will be 41 participants, rather than the maximum limit of 26 which prevails for the other round tables.

Reservations for the manikin demonstration luncheons can be made at the time the reservations for all luncheons and the annual dinner are accepted. *(See notice below for further details)*

ROUND-TABLE AND DINNER RESERVATIONS

Around the middle of July all members of the State Medical Society will receive a special folder, which will include a reservation slip for the round-table luncheons, the annual dinner, and the Monday morning clinical conferences. Inasmuch as a maximum limit is set for each of these functions, members are urged to make their reservations immediately upon receipt of their luncheon notices.

Something NEW

Clinical Conferences

MONDAY—OCTOBER 4

- MILWAUKEE CHILDREN'S HOSPITAL
- MILWAUKEE COUNTY HOSPITAL
- VETERANS HOSPITAL—WOOD

See Next Page For Program

CLINICAL CONFERENCES

1. PEDIATRIC CLINIC—CHILDREN'S HOSPITAL : 721 No. Seventeenth St.

Program arranged by Francis R. Janney, M. D., Wauwatosa

Chairman and Coordinator: John L. Garvey, M. D., Milwaukee

"Neurological Conditions in Infancy and Childhood—Medical and Surgical":

"Medical Aspects, Especially the Meningitides": F. J. Mellencamp, M. D.
"The Outlook and Indications for Surgery of Meningocele": A. A. Schaefer, M. D.
"Subdural Hematoma": Harry P. Maxwell, M. D.
"Brain Abscesses and Brain Tumors": Harry Cleveland, M. D.
"Convulsions": M. G. Peterman, M. D.

Patients will be presented to coordinate the presentations of the above topics.

2. MILWAUKEE COUNTY HOSPITAL CLINIC : 8700 West Wisconsin Ave.*

J. M. King, M. D., and F. D. Murphy, M. D., chairmen

9:00– 9:30 a.m. **"Diseases of the Liver"**
"Diagnosis and Medical Management"—Merle C. F. Lindert, M. D.
"Surgical Management"—James G. Garland, M. D.

9:30–10:00 a.m. **"Peptic Ulcer"**
"Medical Management"—Joseph Shaiken, M. D.
"The Surgery of Its Complications"—Conde F. Conroy, M. D.

10:00–10:30 a.m. **"Peripheral Vascular Diseases"**
"Medical Aspects"—Joseph W. Rastetter, M. D.
"Surgical Management"—Joseph J. Gramling, M. D.

10:30–10:45 a.m. **"Present Status of Colonic Surgery"**—Joseph M. King, M. D.

10:45–11:00 a.m. **"The Proper Use of the Diuretics"**—Francis D. Murphy, M. D.

3. VETERANS HOSPITAL : West National Ave., West Allis*

Maurice Hardgrove, M. D., chairman

9:00– 9:20 a.m. **"Thoracic Amebiasis"**—Mischa J. Lustok, M. D., and Mark W. Garry, M. D.

9:20– 9:40 a.m. **"Arthritis"**—Joseph J. Furlong, M. D., and Ray Piaskoski, M. D.

9:40–10:00 a.m. **"Peripheral Vascular Disease"**—Robert A. Frisch, M. D., and Ralph T. Cunningham, M. D.

Forrester Raine, M. D., chairman

10:00–10:20 a.m. **"Thrombophlebitis"**—James M. Sullivan, M. D., and Howard L. Correll, M. D.

10:20–10:40 a.m. **"Peptic Ulcer: Surgical Treatment"**—Charles M. Schroeder, M. D.

10:40–11:00 a.m. **"Plastic Principles of Use in General Surgery"**—William H. Frackelton, M. D.

Reservations Required!

★ **Maximum attendance at each clinic: 100. You will receive a reservation form with your round-table announcement in July. Be sure you specify which clinical conference you will attend!**

* **Transportation to Wood and Milwaukee County Hospital provided** *if requested at time of reservation.*

All Sections On WEDNESDAY-OCT. 6

GENERAL PRACTICE — Woodruff Smith, M. D., Chairman

Speakers: "The Care of Hip Fractures in a Rural Community": R. L. MacCornack, M. D., and R. M. Rogers, M. D., Whitehall

"Some Aspects of Cardiovascular Disease in the Elderly Patient": H. P. Greeley, M. D., Boston

"The Handling of the Menopause Group": H. M. Murdock, M. D., Towson, Maryland

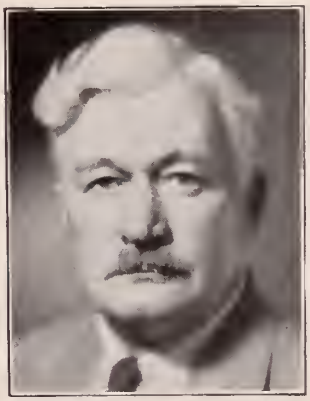
INTERNAL MEDICINE — Elwood Mason, M. D., Chairman

Speakers: "Some Aspects of Nutritional Anemias": J. B. Youmans, M. D., Chicago

"Treatment of Tuberculosis with Streptomycin": G. C. Owen, M. D., Milwaukee

"Diagnosis of Lymph Node Enlargement": J. S. Hirschboeck, M. D., Milwaukee

"Arthritis": R. H. Freyberg, M. D., New York City



OBSTETRICS & GYNECOLOGY — C. S. Harper, M. D., Chairman

Speakers: "The Physiology of the Endocrines as Related to Obstetrics and Gynecology": R. K. Meyer, Ph. D., Madison

"The Use and Abuse of Endocrine Products in Obstetrics and Gynecology": P. F. Schneider, M. D., Evanston, Illinois

"Eclamptic Toxemia": Frank Whitacre, M. D., Memphis, Tennessee

"Distribution of Whole Blood, Blood Plasma, and Blood Products Through Community Blood Banks"; W. D. Stovall, M. D., Madison

OPHTHALMOLOGY & OTOLARYNGOLOGY — J. K. Trumbo, M. D., Chairman

Speakers: "Clinical Allergy for the Nose and Throat Specialists": T. L. Squier, M. D., Milwaukee

"The Fenestration Operation: Selection of Cases and Training of the Surgeon": G. E. Shambaugh, Jr., M. D., Chicago

"The Accommodative and Convergence Factors in Refraction": A. D. Prangen, M. D., Minneapolis

"The Incision and Closure of the Wound in Cataract Operations": F. A. Davis, Madison

[Continued on Next Page]

PEDIATRICS — M. G. Peterman, M. D., Chairman

Speakers: "Exophthalmic Goiter in Children": R. L. J. Kennedy, M. D., Rochester, Minnesota

"Practical Aspects of Electroencephalography": F. A. Gibbs, M. D., Chicago

"Differential Developmental Diagnosis": Arnold Gesell, M. D., New Haven, Connecticut

"Pediatric Allergy": W. A. McGee, M. D., Richmond, Virginia

"What the Practitioner May Expect from the Laboratory": Gorton Ritchie, M. D., Milwaukee

"Some Problems in Roentgenology in Children": J. L. Marks, M. D., Milwaukee

RADIOLOGY — S. R. Beatty, M. D., Chairman

Speaker: B. R. Kirklin, M. D., Rochester, Minnesota

Case reports presented by: E. A. Pohle, M. D., and J. H. Juhl, M. D., Madison; H. W. Hefke, M. D., Milwaukee; S. A. Morton, M. D., Milwaukee; H. H. Wright, M. D., Milwaukee; and L. W. Paul, M. D., Madison

SURGERY — F. D. Weeks, M. D., Chairman

Speakers: "Carcinoma of the Ampulla of Vater": K. E. Lemmer, M. D., Madison

"Present Status of Vagal Resection": P. A. Midelfart, M. D., Eau Claire

"Carcinoma of the Breast": C. W. Eberbach, M. D., Milwaukee

"The Surgical Treatment of Colon Malignancy": O. H. Wangensteen, M. D., Minneapolis

"The Surgical Treatment of Peripheral Vascular Disease": M. E. DeBakey, M. D., New Orleans

EXHIBITS:

A large selection of scientific and technical exhibits will be presented, covering the entire floor space of the Milwaukee Auditorium Main Arena. F. W. Madison, M. D., Milwaukee, is in charge of the selection of scientific exhibits, and his final listing of all scientific exhibits will be carried in the August issue of *The Journal.*

SMOKER:

On Monday, October 4, the State Medical Society will present its annual evening of informal entertainment for the benefit of exhibitors and physicians in attendance at the Annual Meeting. It will be an evening of relaxation and good-fellowship.

Council Committee Appointments

The chairman of the Council, Dr. S. E. Gavin, has announced the following Council committee appointments for 1948:

Committee on Audit and Budget

H. H. Christofferson, M. D., Colby, chairman
J. M. Bell, M. D., Peshtigo
C. O. Vingom, M. D., Madison
R. E. Fitzgerald, M. D., Milwaukee
J. F. Wilkinson, M. D., Oconomowoc

Conference Committee on Open Panels

R. M. Kurten, M. D., chairman
J. P. Malec, M. D., Madison
Millard Tufts, M. D., Milwaukee

Committee Advisory to the Department of Veterans Affairs

B. J. Hughes, M. D., Winnebago
S. M. Evans, M. D., Milwaukee
A. J. Wiesender, M. D., Berlin
W. S. Middleton, M. D., Madison
R. W. Blumenthal, M. D., Milwaukee
J. S. Supernaw, M. D., Madison, chairman, Operating Committee, Veterans Medical Service

Committee on War Records

R. W. Blumenthal, M. D., Milwaukee, chairman
A. H. Gundersen, M. D., La Crosse
K. K. Borsack, M. D., Fond du Lac

Committee on School Health

C. N. Neupert, M. D., Madison, chairman, State Health Officer
Norbert Enzer, M. D., Milwaukee, Committee on Health and Public Instruction
R. L. MacCornack, M. D., Whitehall, Committee on Rural Health and Accident Prevention
L. O. Simenstad, M. D., Osceola, Committee on Tuberculosis and Chest Diseases
H. A. Sincock, M. D., Superior, Committee on Care of Crippled Children

Advisory Committee on Advertising

Harry Beckman, M. D., Milwaukee
A. L. Tatum, M. D., Madison
A. S. Jackson, M. D., Madison

Committee on Extension of Insurance

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L. A. Copps, M. D., Marshfield
G. W. Carlson, M. D., Appleton
Charles Fidler, M. D., Milwaukee
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H. E. Kasten, M. D., Beloit

Committee on Venereal Diseases

Milton Trautmann, M. D., Prairie du Sac, Chairman
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O. A. Stiennon, M. D., Green Bay
G. A. Cooper, M. D., Madison

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J. S. Supernaw, M. D., Madison, chairman, 1951
W. C. Finn, M. D., Fond du Lac, 1950
Maurice Hardgrove, M. D., Milwaukee, 1949
F. D. Weeks, M. D., Ashland, 1952
J. L. Moffett, M. D., Platteville, 1953

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Mary Byard Davis

With the death of Mrs. Mary Byard Davis, executive assistant of the State Medical Society of Wisconsin, on May 12, 1948, the physicians of this state lost one of their most loyal and willing co-partners in the cause of health. Mrs. Davis had charge of the development of the highly successful radio health education program known as "The March of Medicine."

Born at Warren, Ohio, in 1906, Mrs. Davis completed her grammar and high school education in her home city. She was graduated from Ward Belmont Junior College, Nashville, Tennessee, in 1925 and came to Wisconsin a short time later. She was graduated from the University of Wisconsin in 1928 where she was a member of Kappa Kappa Gamma sorority. Since her graduation she had played an active and prominent role in alumni activities.

Mrs. Davis served as a research assistant in the University of Wisconsin psychology department and from 1929 to 1940 in the office of the president of the University, where she was secretary to the late President Glenn Frank. Active in Republican party activities, Mrs. Davis was state women's chairman in the presidential campaign on behalf of the late Wendell Willkie in 1944.

When she came to the State Medical Society in January, 1945, Mrs. Davis brought with her a warm personality and a sincerity of purpose that had won the high regard and affection of hundreds of persons around the state. She immediately began the development of the radio program, "The March of Medicine," a completely new and uncharted field in medical society activities. Working closely with Dr. Llewellyn R. Cole of the University of Wisconsin, who produces the program, and with the Society's Committee on Health and Public Instruction, she moulded a health education program that soon claimed the attention of radio people, health educators and the public. With efficiency, foresight and boundless energy she obtained the program's acceptance as a public service feature by 23 radio stations which broadcast the program each week.

The president and the Council of the State Medical Society had this to say of Mrs. Davis:

> "When she came to our office she was given a task that was new to us. It was her task to initiate a program of health education to be broadcast to the people of Wisconsin. Her success in this work is recognized by all of us, by the managers and announcers of the many radio stations whom she enlisted in her campaign to bring the principle of healthful living to everyone who listened. She demonstrated in the choice of material for these programs a highly intelligent understanding of the importance of health to the happiness of people. She was suited for this work because of her interest in the welfare of all people."

The wives of State Medical Society members will remember Mrs. Davis as the efficient and cordial person who arranged many of their meetings, handled publicity and compiled reports for the Woman's Auxiliary of the State Medical Society. She did much to foster better relations between the medical profession and the press, and was responsible for the wide acceptance of the Society's weekly health items in the state's newspapers. As an active participant in the Wisconsin State Organization of Public Health Nursing, she contributed much to its meetings.

Mrs. Davis had many interests and many talents. The greatest of these, no doubt, was people. She had more than the know-how needed to do a job. She had the ability to inspire confidence, the art of mastering personality differences and the desire to learn. The combination made her a true and good friend of all who knew her.

Funeral services were held in Madison on Thursday, May 13, with the Reverend John O. Patterson, rector of the Grace Episcopal church officiating. Burial was at Warren, Ohio.

Cancer Diagnostic Teaching Clinics

The Teaching Faculty

HARRY S. N. GREENE, M. D.
Professor of Pathology, Yale University School of Medicine, New Haven

L. W. PAUL, M. D.
Professor of Radiology, University of Wisconsin Medical School, Madison

J. H. RANDALL, M. D.
First Assistant, Department of Obstetrics and Gynecology, University of Iowa Medical School, Iowa City

EVERETT D. SUGARBAKER, M. D.
Sugarbaker Clinic, Jefferson City, Mo.

Locations and Dates

RACINE
MEMORIAL HALL, 7th & LAKE
WEDNESDAY, JULY 14

FOND DU LAC
HOTEL RETLAW
THURSDAY, JULY 15

STEVENS POINT
HARDWARE MUTUALS AUDITORIUM
FRIDAY, JULY 16

LA CROSSE
HOTEL STODDARD
MONDAY, JULY 19

JANESVILLE
HOTEL MONTEREY
TUESDAY, JULY 20

SEE REVERSE SIDE FOR PROGRAM

Scientific Program and Luncheon

A. R. CURRERI, M. D.

W. S. BUMP, M. D.

12:00	:	Luncheon for Physicians Speaker: Harry S. N. Greene, M. D., New Haven: "A Biological Test for Cancer"
P. M.		
1:30	:	Medical Lecture: "Cancer of the Colon and Rectum" Everett D. Sugarbaker, M. D., Jefferson City, Mo.
2:30	:	Medical Lecture: "Roentgen Diagnosis of Carcinoma of the Colon" L. W. Paul, M. D., Madison
3:30	:	Medical Lecture: "Cancer of the Cervix" J. H. Randall, M. D., Iowa City
4:30	:	Discussion Period

2:00	:	Public Meeting with Doctor Randall as Lecturer Topic: "The Layman's Responsibility in Cancer Control"

Locations:

Racine—Woman's Club Building; Fond du Lac—Hotel Retlaw; Stevens Point—Elk's Club; La Crosse—Vocational School; Janesville—Woman's Club Building.

Reservations Please!

Through the treasury of the State Medical Society and funds made available through the Wisconsin Division of the American Cancer Society these clinics are open to SMS members without charge. However, reservations are necessary for the noon luncheon.

RESERVATIONS FOR LUNCHEON REQUIRED . . .

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New Haven, Conn.

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C. H. CROWNHART, Secretary
State Medical Society
917 Tenney Bldg., Madison, Wis.

RECENT WISCONSIN LICENTIATES

At a meeting held in Madison on April 22–23, the Wisconsin State Board of Medical Examiners granted licenses through reciprocity to the following physicians.

Name	School of Graduation	Year	Address
Bair, George W.	Illinois	1945	Platteville
Bauer, Donald D.	McGill (Canada)	1942	113½ East Miner Ave., Ladysmith
Cameron, William G.	Rush	1939	148 Newton St., Eau Claire
* Horak, Oliver A.	Nebraska	1943	2123 North Mulligan, Chicago
* Hughson, Donald T.	Yale	1927	Madison, Conn.
Jenk, Lloyd F.	Iowa	1943	313 Potter St., Madison
Kemper, Charles A.	Maryland	1943	531½ Cochrane St., Eau Claire
Killian, Edgar W.	Loyola	1944	5637 South Rockwell St., Chicago
Knutson, Donald L.	Marquette	1945	636 North 104th Street, Wauwatosa
Koff, Salmon A.	Illinois	1929	2135 West Lawn Ave., Madison
Koon, William D.	Harvard	1938	7344 Poe Ave., Detroit, Mich.
NcNally, Howard J.	Loyola	1936	5741 Old Sauk Road, Madison
Meisinger, George F.	Loyola	1943	848 Easy Street, Waukesha
Mikolajezak, Norbert A.	Marquette	1945	2000 North Fifty-ninth St., Milwaukee
Mohler, George T.	Columbia	1944	414½ Chestnut St., Eau Claire
Moore, John C.	Pennsylvania	1943	Dean Clinic, Madison
Orr, Charles P.	Northwestern	1944	1715 North Thirty-fifth, Milwaukee
Radke, Albert W.	Northwestern	1943	7416 Harwood Ave., Milwaukee
Rieman, Robert W.	Minnesota	1943	816 Greenfield, Waukesha
Sandeno, Morris T.	Marquette	1945	2923 South Forty-ninth, Milwaukee
Schoene, Fred C.	George Washington	1945	1219 Summit Ave., Waukesha
Soucek, Adolph	Iowa	1931	Mendota State Hospital, Madison
Sundquist, Glenn V.	Oklahoma	1945	8844 West Watertown Plank Road, Milwaukee
Szilagyi, Miklos J.	Loyola	1937	3116 South Quincy Ave., Milwaukee
Town, Floyd R.	Michigan	1945	1813 Woodland Court, Eau Claire

* Incomplete applications.

SOCIETY PROCEEDINGS

Brown—Kewaunee—Door

N. C. GILBERT

Guest speakers at the May meeting of the Brown–Kewaunee–Door County Medical Society were two specialists in internal medicine, *Drs. Howard L. Correll* of Milwaukee and N. C. Gilbert of Chicago. Doctor Correll discussed "The Causes of Death in Patients Past 70," and Doctor Gilbert spoke on "Geriatrics." Doctor Gilbert is professor of medicine at Northwestern University Medical School and senior attending physician at St. Luke's Hospital, Chicago. The meeting, which was the last of the season, was held at the Beaumont Hotel, Green Bay, on May 13, and dinner preceded the scientific program.

Jefferson

Dr. Hertha Tarrasch, Janesville, discussed the activities of the child guidance clinic of Jefferson County at a meeting of the Jefferson County Medical Society held at Chauncey's in Pipersville on April 22. At the meeting, a committee of three, *Dr. O. F. Dierker* of Watertown, *Dr. E. A. Schoenecker* of Lake Mills, and *Dr J. J. Harris* of Fort Atkinson, was appointed to establish a fee schedule for eye, ear, nose, and throat work on county welfare patients.

Chippewa

L. L. SWAN

Meeting at the Hotel Northern in Chippewa Falls, members of the Chippewa County Medical Society heard a talk by *Dr. L. L. Swan*, a member of the staff of the State Laboratory of Hygiene in Madison. Doctor Swan spoke on "The Clinical Significance of the Papanicolaou Smear Method of Diagnosis of Cervical Cancer."

Portage

H. W. WIRKA

Eske Lodge in Stevens Point was the meeting place for the Portage County Medical Society on May 11. *Dr. Herman Wirka*, associate professor of orthopedic surgery at the University of Wisconsin Medical School, presented a paper on "Fractures about the Elbow in Children." *Drs. Maurice Rice* and *W. F. Cowan* were the discussants.

Rusk

Members of the Rusk County Medical Society met at the Country Club in Ladysmith on May 14 to hear a talk by Dr. Arthur Grollman of Dallas, Texas. Doctor Grollman, who is professor of experimental medicine at Southwestern Medical College in Dallas, discussed "Endocrinology and Therapeutics."

Two staff members of the Duluth Clinic in Duluth were guest speakers at a meeting of the Rusk County Medical Society held at the American Legion Hall in Ladysmith on April 29. Dr. F. J. Hirschboeck presented a paper on the "Treatment of Heart Failure," and Dr. J. Coll spoke on "Thrombotic and Embolic Conditions."

Sheboygan

"The Treatment of Benign Prostatic Hypertrophy with Estrogens" was discussed when members of the Sheboygan County Medical Society met at St. Nicholas Hospital in Sheboygan on April 27. The guest speaker was *Dr. Robert S. Irwin* of Milwaukee.

Walworth

Meeting at the Hotel Burlington at Burlington on May 13, members of the Walworth County Medical Society heard *Dr. G. S. Kilkenny* of Milwaukee speak on "Obstetrical Emergencies." An open discussion followed the paper.

Dr. William H. Frackelton of Milwaukee gave an illustrated lecture on "Salvaging the Injured Hand" when the Society met at Sturtevant's Restaurant in La Grange on April 15. Members of the Auxiliary were invited to a dinner preceding the scientific session.

Winnebago and Fond du Lac

The Fond du Lac and Winnebago County Medical Societies were guests of *Dr. Byron J. Hughes* at the Winnebago State Hospital on May 6. Papers were presented by members of the hospital staff, and a film on a prefrontal lobotomy performed at Winnebago State Hospital with a presentation of postoperative cases and discussion was given by Doctor Hughes. *Dr. J. T. Petersik* discussed the "Incidence of Huntington's Chorea at Winnebago State Hospital"; *Dr. L. B. Perssion* spoke on "The Results of Shock Therapy in 25 Cases"; and *Dr. J. J. Mulvaney* presented a paper on the "Incidence of Tuberculosis at Winnebago State Hospital."

Washington—Ozaukee

C. M. KURTZ

A clinic on heart disease was presented by *Dr. C. M. Kurtz*, Madison, to members of the Washington – Ozaukee County Medical Society when they met at St. Joseph's Hospital in West Bend on April 24. Ten patients appeared for examination and discussion as part of the clinic.

Wisconsin Surgical Society

The meeting of the Wisconsin Surgical Society was held in Marshfield on May 15. The morning was devoted to operative clinics held at St. Joseph's Hospital, and the afternoon session consisted of scientific papers presented by members of the Marshfield Clinic. *Dr. E. J. McGinn* discussed "Peritoneal Lavage for Uremia"; *Dr. R. S. Baldwin* spoke on "Surgery on a Patient with Diabetes Mellitus"; *Dr. F. J. Gouze* talked on the "Preparation of Thyroid Patients for Surgery"; *Dr. J. M. Wickham* discussed the "Use of X-Ray in Carcinoma of the Breast"; and *Dr. Paul Doege* spoke on "Carcinoma of the Colon and Its Management." The papers were discussed by members of the Society.

Following the scientific program a business meeting was held, and election of officers resulted in the election of *Dr. Carl Eberbach*, Milwaukee, president-elect; *Dr. Warner S. Bump*, Rhinelander, secretary-treasurer; and *Dr. Frank D. Weeks*, Ashland, recorder. *Drs. Kenneth E. Lemmer*, Madison, and *Victor F. Marshall*, Appleton, were elected to the Council to succeed Doctor Eberbach and *Dr. Arnold S. Jackson*, Madison.

The following physicians were elected to membership: *Drs. W. P. Curran*, Antigo; *George N. Gillett*, Racine; *Dwight B. Fishwick*, *Philip H. Seefeld*, and *Charles M. Schroeder*, all of Milwaukee; *J. A. Killins*, Green Bay; *Samuel B. Harper*, *Otto V. Hibma*, and *John Malec*, all of Madison; *Joseph A. Rawlins*, Elkhorn; and *Maurice Rice*, Stevens Point.

At the dinner meeting in the evening the features of the program were the presidential address, "The Changing Horizon in Surgery" by *Dr. Erwin R. Schmidt*, Madison, and the special address by guest

"... a considerable reservoir of unsuspected and unreported amebiasis has been brought back to the United States...."[1]

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1. *Editorial: The Problem of Amebiasis, J.A.M.A.* 134:*1095* (*July 26*) *1947.*
2. *Wilbur, D. L., and Camp, J. D.: Amebic Disease of the Cecum: Clinical and Radiological Aspects, Gastroenterology* 7:*535* (*Nov.*) *1946.*
3. *Morton, T. C. St. C.: Diodoquin for Chronic Amoebic Dysentery in Service Personnel Invalided from India, Brit. M.J.* 1:*831* (*June 16*) *1945.*

Diodoquin is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

speaker Dr. Richard Varco, University of Minnesota Medical School, who spoke on "The Surgical Treatment of Certain Congenital Anomalies of the Heart and Great Vessels."

Section on Radiology

The Section on Radiology of the State Medical Society held its annual meeting May 14 and 15 at the Hotel Athearn in Oshkosh. The chairman, *Dr. S. R. Beatty*, Oshkosh, presided. Friday afternoon was devoted to reports of cases and a film-reading session, followed by a short business meeting. On Saturday there was a scientific session, and the main business meeting was held, with election of officers. Doctors named to positions, beginning at the time of the Annual Meeting of the State Medical Society, were *Drs. R. L. Troup*, Green Bay, chairman; *J. L. Armbruster*, Milwaukee, vice-chairman; and *A. Melamed*, Milwaukee, secretary-treasurer. Doctor Beatty, Oshkosh, was named a member of the executive committee, replacing *Dr. M. C. Pritchard* of Eau Claire. The other members of the executive committee are Doctor Armbruster, Milwaukee, and *Dr. E. A. Pohle*, Madison. *Dr. L. V. Littig*, Madison, was elected delegate to the State Medical Society, with *Dr. W. T. Clark*, Janesville, alternate delegate. *Dr. S. A. Morton*, Milwaukee is councilor to the Radiological Society, and *Dr. J. E. Habbe*, Milwaukee, councilor to the American College of Radiology.

It was voted to hold the spring meeting of the Section at Green Bay.

News Items and Personals

Dr. William Reese Observes Ninetieth Birthday

Friends and neighbors of *Dr. William Reese*, widely known physician from Dodgeville, gathered at his home on April 19 to observe with him his ninetieth birthday anniversary. A birthday cake weighing one hundred and five pounds had been brought from Chicago in honor of the occasion, and the doctor was remembered with numerous gifts and cards.

Doctor Reese, who is still carrying on his practice, has practiced in Dodgeville for fifty years. A native of Ridgeway, he began his medical education in 1894, graduating from Illinois Medical College, Chicago, in 1898. The following year he settled in Dodgeville.

Dr. C. R. Kwapy Returns to Oconto Practice

Dr. C. R. Kwapy, who spent seven months studying and practicing in California, returned to Oconto to resume practice there on May 1. Following his reestablishment of work, he plans to leave for a year's residency in eye, ear, nose, and throat work at Milwaukee County General Hospital. During his stay in California, he took specialized studies in eye, ear, nose, and throat treatment at the University of Southern California School of Medicine, following which he joined the staff of California Hospital, Los Angeles.

Mrs. Rush Godfrey Establishes Trust Fund in Honor of Late Doctor Godfrey

A trust fund, to be known as the Dr. Rush Godfrey Medical Scholarship Fund, has been established by Mrs. Rush Godfrey of Lancaster in honor of her late husband, who died April 14, 1947. Interest from the fund will be used for the education of a boy or girl in the practice of medicine.

Dr. Rush Godfrey, whose father was Dr. Joseph Godfrey, was graduated from the University of Wisconsin Medical School and the University of Pennsylvania School of Medicine. He practiced in Lancaster for more than thirty years.

Dr. C. P. Haseltine to Join Staff of New York Hospital

Dr. Charles P. Haseltine, a former Ripon resident who recently completed graduate work in ophthalmology at Harvard Medical School, Boston, has received an appointment as resident physician at the New York Eye and Ear Hospital in New York. Doctor Haseltine will assume his duties there on October 1.

Dr. R. R. Jacks Opens New Office in Racine

Dr. Robert R. Jacks, Racine, recently opened an office in the Proost Building, Racine, for the private practice of medicine. Doctor Jacks previously was associated with the J. I. Case Company of that city as industrial physician.

Drs. T. E. Malloy and J. A. Russell Open New Offices in Random Lake

Drs. T. E. Malloy and *J. A. Russell* are now located in their new office building in Random Lake. The building houses a waiting room, two treatment rooms, a drug room, and a private office, all of which are furnished with modern equipment.

Surgeons Certified by International Board

The following Wisconsin surgeons were recently certified as specialists by the International Board of Surgery:

General Surgery

William J. Carson, M. D., Milwaukee
Paul F. Doege, M. D., Marshfield
Harold R. Fehland, M. D., Wausau
Will B. Gnagi, M. D., Monroe
Jerry W. McRoberts, M. D., Sheboygan

Ophthalmology and Otolaryngology

Samuel G. Higgins, M. D., Milwaukee
Herbert G. Schmidt, M. D., Milwaukee
Ralph P. Sproule, M. D., Milwaukee

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HERBERT W. POWERS, M.D

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Orthopedic Surgery

Lemuel D. Smith, M. D., Milwaukee

Urologic Surgery

Walter M. Kearns, M. D., Milwaukee

Obstetrics and Gynecology

Rudolph W. Roethke, M. D., Milwaukee
Victor F. Marshall, M. D., Appleton
Alexander W. Montgomery, M. D., Milwaukee
Karl F. Schlaepfer, M. D., Milwaukee
Joseph M. Shramek, M. D., La Crosse

New Glarus Doctor Leaves For European Trip

Sailing from New York on May 19, Dr. and Mrs. *S. J. Francois*, New Glarus, will visit relatives in France, Belgium, and Switzerland. They left New Glarus on May 10, and plan to travel through the European countries by auto.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. A. S. Jackson Named Head of Goiter Society

A. S. JACKSON

Dr. Arnold S. Jackson recently attended the annual meeting of the American Association for the Study of Goiter at Toronto, Canada, where he was installed as president of the group. Doctor Jackson, elected to the position a year ago, succeeds Dr. J. H. Means of Boston.

Dr. B. H. Roisum Begins Practice in Oregon

Dr. Bryant H. Roisum, formerly of Madison, on May 24 took over the house and practice of *Dr. T. H. Joyner* in Oregon. Doctor Joyner left his practice in that community to accept the position of medical superintendent at Mountain Hospital, Asheville, North Carolina.

Doctor Roisum, a graduate of the University of Wisconsin Medical School, began working in Oregon on May 2. He was separated from the Army Medical Corps in 1946, following three years of service.

Madison Doctors Return From Convention

Drs. John E. Gonce, Jr., and *R. E. Campbell*, both of the staff of the University of Wisconsin Medical School, recently spoke at the annual meeting of the Nebraska State Medical Association. Doctor Gonce is professor of pediatrics, and Doctor Campbell is professor of obstetrics and gynecology at the university.

Dr. E. A. Pohle Speaks at Conference on Malignancies

E. A. POHLE

Dr. E. A. Pohle, professor of radiology at the University of Wisconsin Medical School, returned from Indianapolis on April 11 after speaking at a symposium on malignant diseases at the Indiana University Medical Center. His discussion covered the use of x-rays and radium in the treatment of cancer.

Noted Physicians Speak at University Medical School

Two internationally known physicians spoke at the University of Wisconsin Medical School late in May.

An authority on the functions and diseases of the kidney and a noted biochemist, Dr. Edward J. Conway, Dublin, Ireland, appeared at the Service Memorial Institutes Building on May 25 to discuss "Inorganic Levels in the Blood." Doctor Conway is professor of biochemistry at the University College in Dublin.

Acknowledged

"MERCURIAL DIURETICS IN HEART FAILURE.—. . . They often yield splendid results in individuals in whom physical signs of dropsy are lacking but water retention is demonstrated by the large loss of weight that follows the administration of a diuretic."

Fishberg, A. M.: Heart Failure, 2nd Ed., Phila., Lea & Febiger, 1946, p. 733.

"IN PERSONS WITH HYPERTENSION and in instances of heart failure with pulmonary congestion but without peripheral edema, mercurial diuretics may be helpful in hastening the loss of sodium or in permitting a somewhat more liberal diet. . . . In most cases hypertensive patients with normal blood urea levels can be safely tried on sodium depletion."

The Treatment of Hypertension, editorial, J. A. M. A. 135:576 (Nov. 1) 1947.

". . . [By] the more frequent usage of the mercurials in cardiac dyspnea the attending physician . . . PROLONGS THE LIFE AND COMFORT of his patient."

Donovan, M. A.: New York State J. Med. 45:1756 (Aug. 15) 1945.

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well tolerated locally, a diuretic of choice

- "Local effects of intramuscular injection. . . . The results strongly favored MERCUHYDRIN."

  Modell, W., Gold, H. and Clarke, D. A.: J. Pharm. & Exper. Therap. 84:284 (July) 1945.

- "The authors favor the administration of mercury intramuscularly rather than intravenously and for this purpose employ preparations such as MERCUHYDRIN."

  Thorn, G. W. and Tyler, F. H.: Med. Clin. North America (Sept.) 1947, p. 1081.

- "The results of our experiments suggest that the greatest cardiac toleration for mercurial diuretic occurs with MERCUHYDRIN."

  Chapman, D. W. and Shaffer, C. F.: Arch. Internal Med. 79:449, 1947.

- "We have limited the use of chemical diuretics almost entirely to . . . MERCUHYDRIN."

  Weiser, F. A.: Grace Hospital Bulletin, Detroit (Jan.) 1947, p. 25.

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On May 28, Dr. Henry Foy, director of the Wellcome Trust Research Laboratories in London, England, lectured on "Hemoglobinemia and Hemoglobinuria." Doctor Foy, who also spoke in the Service Memorial Institutes Building, is much interested in the subject of blackwater fever, a severe form of malaria, and many of his observations brought out in the lecture were the results of that interest.

Dr. W. F. Lorenz Heads Madison Anti-Venereal Disease Campaign

W. F. LORENZ

Dr. W. F. Lorenz, director of the psychiatric institute of the State of Wisconsin General Hospital, has been named Madison chairman of a Stamp-Out VD Campaign, to solicit contributions for a fight against venereal disease. Funds raised in the drive will go to the American Social Hygiene Association, a national voluntary agency leading efforts against venereal diseases.

Dr. M. J. Musser Addresses Social Workers

M. J. MUSSER

Dr. Marc J. Musser, Madison, was present at the annual dinner meeting of the American Association of Medical Social Workers of the Wisconsin area on May 20 in Milwaukee to discuss "Environment and Psychosomatic Medicine." Doctor Musser is associate professor of medicine at the University of Wisconsin Medical School.

University Medical School Holds Field Day

Dr. Lowell T. Coggeshall, dean of the University of Chicago School of Medicine and a former research assistant in zoology at the University of Wisconsin, was the featured speaker at the Annual Medical School Field Day, May 19, at the University of Wisconsin Medical School. Sponsored by the Sigma Sigma medical honor fraternity, he discussed "Immunology and Chemotherapy of Malaria."

The program for the day, which is presented annually by the medical students at the University, included papers on student research, scientific exhibits by the students, a student-faculty luncheon, and a period of athletic events at the university athletic fields. A banquet was held in the Memorial Union in the evening, at which *Dr. William S. Middleton*, dean of the University of Wisconsin Medical School, was the speaker.

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

FRITZ KANT

A representative of Alcoholics Anonymous was present with *Dr. Fritz Kant*, Madison, to speak at the May meeting of the Columbia-Marquette – Adams County Medical Society, held at Hotel Portage in Portage on May 11. The topic for discussion was "Aversion Treatment of Alcoholics."

Sauk

The Sauk County Medical Society met in the Silver Room of the Warren Hotel in Baraboo on April 15. *Dr. Llewelyn R. Cole*, coordinator of graduate medical education at the University of Wisconsin Medical School, was present to speak to the group.

TWELFTH DISTRICT NEWS

Reunion of Wisconsin Medical Alumni Held in Milwaukee

W. S. MIDDLETON

Drs. Ralph P. Sproule, A. R. Langjahr, and *R. A. Toepfer* were in charge of arrangements for the reunion dinner for University of Wisconsin Medical School alumni at the University Club of Milwaukee on May 20. *Dr. William S. Middleton*, dean of the medical school, was the dinner speaker. Other guests of honor included *Dr. William F. Lorenz*, director of the psychiatric institute at the University of Wisconsin, and Mr. Harry Stuhldreher, football coach.

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Milwaukee Doctor Honored at Reunion of Northwestern Medical Alumni

Dr. Albert E. Yanke, Milwaukee, graduate of the Northwestern University Medical School in 1898, was one of twenty members of his class honored at the annual faculty-alumni reunion dinner on May 8 in Evanston, Illinois. Doctor Yanke received a golden certificate in honor of the fiftieth anniversary.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

"Cardiac Decompensation" was the subject for discussion at a meeting of the Milwaukee Academy of Medicine held at the University Club of Milwaukee on May 18. Guest speaker was Dr. Thomas J. Dry, assistant professor of medicine at the University of Minnesota Medical School and consultant in the section on cardiology at Mayo Clinic, Rochester, Minnesota.

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society heard a talk by Dr. W. Horsley Gantt, Baltimore, Maryland, when they met at the University Club of Milwaukee on May 25. Doctor Gantt, who is head of the Pavlovian Laboratory at Johns Hopkins Hospital, discussed the "Origin and Mechanism of Experimental Neurosis."

SOCIETY RECORDS

New Members

Victor S. Falk, Shearer Clinic, Edgerton

Robert C. Randolph, 1300 University Avenue, Madison

John J. Mulvaney, Winnebago State Hospital, Winnebago

Wayne J. Fencil, Monroe Clinic, Monroe

Chester S. Kopp, Rocky Knoll Sanatorium, Plymouth

Richard R. Jandrain, Luxemburg

Owen C. Berg, 238 West Wisconsin Avenue, Milwaukee

Robert E. Yunck, 2750 North Prospect Avenue, Milwaukee

Glenford L. Bellis, Sunny View Sanatorium, Winnebago

Bart E. McGonigle, Baraboo

Changes in Address

C. A. Morrow, Viola, to 6339 Eighth Avenue, Kenosha

T. W. Dasler, Madison, to Dells Clinic, Wisconsin Dells

A. M. Kurzon, Cudahy, to 238 West Wisconsin Avenue, Milwaukee

Charles P. Giesen, Battle Creek, Michigan, to 1622 Ogden Avenue, Superior

D. R. Searle, Safety Harbor, Florida, to 1710 Twenty-first Street, Superior

S. J. Moglowsky, Van Nuys, California, to 3722 Long Ridge Avenue, Sherman Oaks, California

J. A. Bartos, Milwaukee, to 707 Oakland Avenue, Waukesha

F. L. Tabrah, Seattle, Washington, to Broadway and Sunset Drive, Bellingham, Washington

B. H. Roisum, San Francisco, California, to Oregon

E. C. Grosskopf, Waukesha, to 152 West Wisconsin Avenue, Milwaukee

NOTE: In the May *Journal*, the name of Thomas J. Beno, M. D., was incorrectly listed as Thomas J. Bens, M. D., among the new members of the Society.

BIRTHS

A son to Dr. and Mrs. George B. Corcoran, Jr., Madison, on May 14.

A son to Dr. and Mrs. George Hammes of Wausau on April 3.

DEATHS

Dr. Donald M. Norton, physician at Medford since 1929, died at his home in that community on May 5. He was 50 years old.

Born at Medford on November 3, 1897, he attended Marquette University School of Medicine, graduating in 1925. Following his internship at Milwaukee County Hospital, he entered the Mayo Foundation as a Fellow in Medicine. In 1928 he returned to Milwaukee County Hospital to complete a residency, and the following year he joined the staff of Medford Clinic, where he practiced until his death.

Doctor Norton had been health commissioner of Medford for a number of years. He was a member of the Price–Taylor County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife.

Dr. Elmer Hiram Parker, retired physician who at one time practiced in River Falls, died at Lake Wales, Florida, on April 19. He had resided in River Falls since his retirement.

Born on a farm in St. Croix County on May 17, 1862, the doctor received his academic training at the University of Wisconsin. Following graduation from Northwestern University Medical School in 1891, he established general practices in Baldwin and later in River Falls before entering nose and throat practice in Minneapolis. The doctor had been retired for a number of years.

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PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Dr. Fred Johnson, Eau Claire physician, died at his home in that city on April 30. He was 76 years old.

Doctor Johnson was born in England on May 29, 1871. He graduated from the Wisconsin College of Physicians and Surgeons at Milwaukee in 1904, following which he established practice in North Freedom. In 1911 he moved to Eau Claire to set up the practice which he maintained until his death.

The doctor was on the staff of Luther Hospital, and was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife.

Dr. Samuel Plahner, well known Milwaukee neuropsychiatrist, died at a Milwaukee hospital, after a brief illness, on May 8. He was 71 years old.

Born in Tannepol, Austria, on August 3, 1877, the doctor received his medical education at the University of Vienna, graduating in 1903. He interned at the General Hospital in Vienna, following which he entered private practice. In 1922 he came to the United States, and in 1926 he received his citizenship papers. He established a neuropsychiatric practice in Milwaukee and later joined the staff of the Evangelical Deaconess Hospital. During World War II Doctor Plahner was psychiatric examiner at the Milwaukee induction center.

The doctor was a member of the Milwaukee Neuro-Psychiatric Society, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving are his wife and a daughter.

Dr. Michael A. Cunningham, the oldest practicing physician in Janesville, died April 24 at his home in that city. The doctor, who was 84 years old, had practiced in Janesville for fifty-three years.

A lifetime resident of Wisconsin, Doctor Cunningham was born December 15, 1863, in Dayton, Green County. He attended Rush Medical College, Chicago, from which he graduated in 1895. Before establishing his practice in Janesville, the doctor practiced at Monroe and Mineral Point for a brief period.

Doctor Cunningham was a member of the Rock County Medical Society, the State Medical Society, and the American Medical Association. He was a former president of the Ancient Order of Hibernians and was associate medical examiner of the Equitable Reserve Association.

He is survived by his wife, a son, and two daughters.

Dr. Paul John Mateicka, 31, a member of the staff of Sacred Heart Sanitarium in Milwaukee, died at his home in Milwaukee on April 13.

Doctor Mateicka was born August 16, 1916. He graduated from the University of Wisconsin Medical School in 1942, interning at the University of Indiana Medical Center, Indianapolis. Following internship, he joined the staff of Sacred Heart Sanitarium.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

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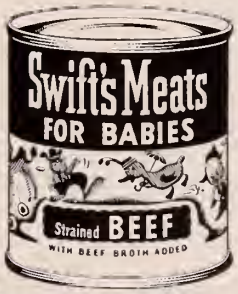

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In Memoriam

The members of the Auxiliary express their sorrow at the death of MRS. EBEN J. CAREY, Milwaukee, a charter member, past state president, and past national president, and at the death of MRS. MARY B. DAVIS, Madison, of the State Medical Society Office, who arranged meetings and handled publicity for the Auxiliary. The Auxiliary will miss their great capacity and desire to serve others.

Ashland—Bayfield—Iron

Members of the Auxiliary sponsored the annual drive for funds to fight cancer.

Dane

The members of the Dane County Auxiliary group from Stoughton were hostesses at the May meeting. A unique luncheon was served at "A Little Bit of Norway" in Stoughton. Officers for the new year were elected. Mrs. David Williams is president; Mrs. C. K. Schubert, president-elect; Mrs. Claud F. Schroeder, treasurer; and Mrs. Llewellyn Cole, secretary.

Sheboygan

The April meeting of the Auxiliary to the Sheboygan County Medical Society was held at Prange's Shore Room. Mrs. T. F. Hilgeman gave an interesting talk on her experiences as a missionary nurse in China for more than seven years. Following the talk a short business meeting was conducted. The Care Fund was duly enlarged by the sale of a gift package contributed by the hostesses, Mrs. Arthur Knauf and Mrs. Homer H. Kohler. A contribution to the Crippled Children's Fund was also voted by the group.

Walworth

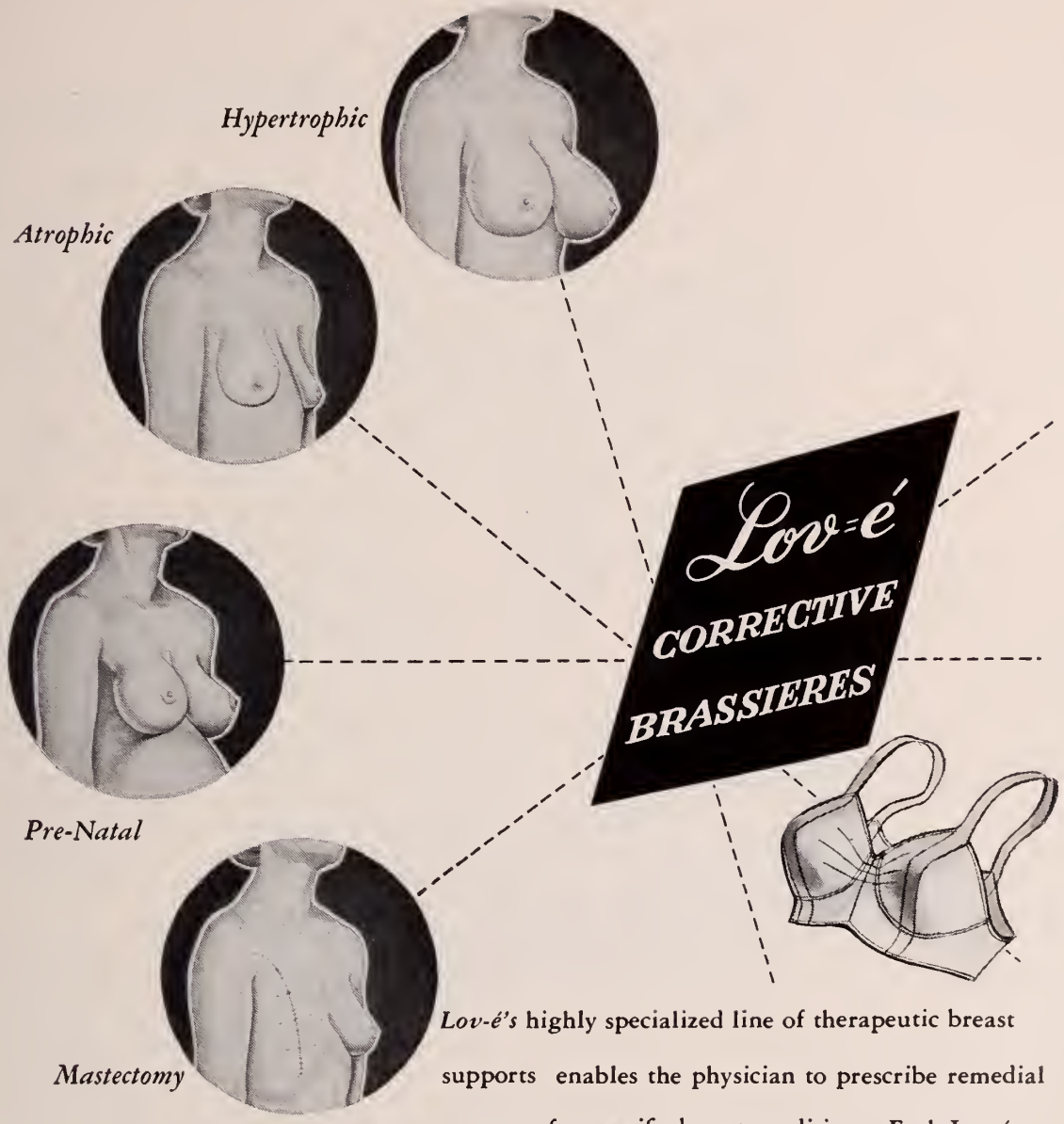
Mrs. E. D. Sorenson, Elkhorn, state chairman of public relations, and state judges announced the following winners from the essays submitted by high school students throughout the state on the subject of "Advantages of Organized Medicine as Planned by the Medical Profession and the Disadvantages of Socialized Medicine as set up by the Politicians": first prize, $50.00, to Marvin Budderman, Amery; second prize, $35.00, Carl Bererter, Kenosha; third prize, $25.00, Vernell Schocht, Kewaskum; fourth, $15.00, Mary Ann Zlatnik, Two Rivers; fifth, $10.00, Albert Jensen, Logan; sixth, Mary Mae Krueger, Whitewater.

This past year, the Auxiliary to the Walworth County Medical Society has purchased a trip film projector for use in the county schools. They have also provided each rural school with a subscription to *Hygeia*.

Winnebago

The members of the Auxiliary to the Winnebago County Medical Society met for their April meeting at the State Hospital. After luncheon, violin selections were presented by a convalescing patient. Dr. Byron Hughes, superintendent of the hospital, then discussed psychiatric problems and the newer methods of surgical treatment. A conducted tour of the hospital was also announced.

Mrs. A. W. Hammond, state president, spoke briefly on the current object of the society, better care of the mentally ill. Members of the Fond du Lac county medical auxiliary were special guests.



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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Diseases of the Nose, Throat and Ear. By William Lincoln Ballenger, M. D., F. A. C. S., Late Professor, School of Medicine, University of Illinois, Chicago; and Howard Charles Ballenger, M. D., F. A. C. A., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Assisted by John Jacob Ballenger, B. S., M. D., Research Fellow in Otolaryngology, Northwestern University School of Medicine, Chicago. Ninth Edition, thoroughly revised. Pp. 993, with 597 illustrations and 16 plates in color. Philadelphia: Lea and Febiger, 1947. Price $12.50.

In this, the ninth edition of "Diseases of the Nose, Throat and Ear," Doctors Ballenger have made the always excellent textbook better. The basic pattern of the book has not been significantly altered. Each entity is again discussed under the divisions of etiology, pathology, symptoms, diagnosis, and treatment. No phase of the specialty has been overlooked, and the well planned organization aids in ready reference to the subject material.

The drawings and photographs are generously placed throughout the entire book. The consecutive steps of various surgical procedures are well outlined and illustrated. The presentation of material is easily read and extraneous discussions have been held to a minimum. Although the basic science portion of some subjects has been rather superficially covered, the clinical aspects are well worth everyone's consideration.

Chapter eight, dealing with headaches, is a timely addition and, though brief, is adequate and valuable. Revisions of the chapters dealing with physiology and functional tests of the labyrinth, inflammatory diseases of the labyrinth, peroral endoscopy, and rhinoplastic reconstructions provide newer concepts and worth while recommendations.

The revised text will be of value to the student, general practitioner, and otolaryngologist as well.—W. M. N.

A Manual of Clinical Therapeutics; A Guide for Students and Practitioners. By Windsor C. Cutting, M. D., Professor of Therapeutics, Stanford University School of Medicine, San Francisco, California. Second Edition. Pp. 172, with 30 illustrations. Philadelphia and London: W. B. Saunders Company, 1948. Price $5.00.

This pocket-sized manual would probably be of most value to the intern or resident on a hospital house staff, but conceivably could also be a ready source of reference to the busy general practitioner. In a direct, orderly manner diseases of definite etiology are first considered, then those classified by their anatomic effects are outlined. Tropical diseases also are included.

Briefly, and in the minimum amount of space, first general measures, then specific measures, and finally prevention are considered for each disease. The discussions are quite limited but each word has value and the generally recognized favorable therapeutic procedures are outlined with specific dosages, routes of administration, and precautions included for each drug. Space in the manual does not permit discussion or inclusion of limited or controversial therapeutic measures, but a section on special procedures contains many helpful diagrams and instruction regarding these technics.

The appendices are particularly well organized and classified.—O. S. O.

Allergy in Theory and Practice. By Robert A. Cooke, M. D., Sc. D., F.A.C.P., Attending Physician and Director of the Department of Allergy, the Roosevelt Hospital, New York City. Pp. 572 with 43 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price $8.00.

This book contains a large volume of excellent material covering the fundamental aspects of allergy, and the various manifestations of allergy, by a group of well known specalists. Outstanding is the discussion of the infective etiology of asthma, allergic rhinitis, dermatitis, and other allergic man-

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ifestations. Allergies of the nervous system, cranial vascular, and digestive systems are extensively discussed. The book should be of interest to the general practitioner, as well as to those engaged in the specialty of allergy.—H.P.D.

Practical Physiological Chemistry. By Philip B. Hawk, Ph.D., President, and Bernard L. Oser, Ph.D., Director, Food Research Laboratories, Inc., New York; and William H. Summerson, Ph.D., Associate Professor of Biochemistry, Cornell University Medical College, New York. Twelfth edition. Pp. 1323, with 329 illustrations and 5 color plates. Philadelphia: The Blakiston Company, 1947. Price $10.00.

The twelfth edition of this book is larger by 355 pages than the previous edition. More than one-half of the chapters have been completely rewritten and the rest revised. The importance of newer methods and technics in biochemistry has been recognized by including discussions of Warburg manometric technics, electrophoresis and protein fractionation, isotopes, photometry, etc. The chapters on hormones, blood, and urine analysis have been considerably enlarged and brought up to date. An entirely new chapter has been added on antibiotics and metabolic antagonists. The appendix has been enlarged and brought up to date to include preparation of new reagents, practical suggestions for care and feeding of animals, a table of nutritional data on foods, etc. The addition of recent review references at the end of each chapter greatly increases the value of this book as a reference text.

While the style of presentation gives this book a student text character, because of the incorporation of outlined laboratory experiments throughout the text, the many excellent practical and theoretic aspects make this book a valuable reference volume for any biochemistry or clinical-chemistry laboratory.

Postgraduate Obstetrics. By William F. Mengert, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Southwestern Medical College, Chairman Obstetrics and Gynecology, Parkland Hospital, Dallas, Texas. Pp. 392 with 123 illustrations. New York and London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1947. Price $5.00.

This is a book written specifically for the family physician. Practical details of some of the common problems are discussed. There are chapters on the care of the newborn, sterility, and some laboratory procedures. The text is well illustrated with some original drawings and many photographs. It will serve as a practical reference book for the general practitioner.—M.J.T.

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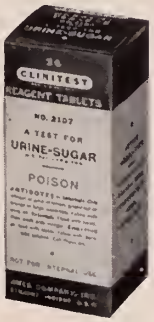

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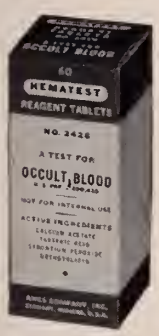

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Textbook of the Ear, Nose, and Throat. By Francis L. Lederer, B. Sc., M. D., F. A. C. S., Professor and Head of Department of Otolaryngology, University of Illinois College of Medicine, Chicago; Chief of the Otolaryngological Service, Research and Educational Hospital; Director of Education and Chief of the Ear, Nose and Throat Services, Illinois Eye and Ear Infirmary; Captain, Medical Corps, United States Naval Reserve; and Abraham R. Hollender, M. Sc., M. D., F. A. C. S., Professor of Otolaryngology, Emeritus, University of Illinois College of Medicine, Chicago; Attending Otolaryngologist, St. Francis Hospital, Miami Beach, Florida. Pp. 596, with 182 illustrations. Second Edition. Philadelphia: F. A. Davis Company, Publishers, 1947.

The revised second edition of this text takes cognizance of the many developments in the field of otolaryngology in recent years. The plan of the book is essentially the same as that of the first edition with each entity discussed under the headings of etiology, symptoms, diagnosis, and treatment. More recent trends in therapy, especially concerning the use of chemotherapeutics and the antibiotics, are fully discussed.

The abundance of illustrations and the exceptionally well organized diagnostic charts emphasize the effort and thought in its preparation. The introductory section in itself, dealing with progress within the specialty, is timely. The constitutional aspects of ear, nose, and throat diseases and the allergy sections stress the importance of these subjects as evidenced by the more recent investigators.

In this edition, as in the first, the fundamental anatomic and physiologic considerations are exceptionally well presented. Didactic otolaryngology is featured over surgical procedure in view of the authors' consideration that the indications for surgical procedures in the specialty are rapidly becoming fewer in number.

It is strongly recommended that this textbook becomes a part of the practitioner's and specialist's library.—W. M. N.

Congenital Malformations of the Heart. By Helen B. Taussig, M. D., Associate Professor of Pediatrics, Johns Hopkins University School of Medicine, and Director of the Children's Cardiac Clinic at the Harriet Lane Home of the Johns Hopkins Hospital. Pp. 618. New York: The Commonwealth Fund, 1947. Price $10.00.

This is an ably written book. It gives the medical man the clearest understanding, to date, of congenital malformations of the heart, a subject, by nature, most complex. The clinical, rather than the pathologic approach is used. Each malformation is presented as a separate clinical entity and the features characteristic of each analyzed. The author, drawing mainly from her own experiences and observations, stresses the importance of the physical examination and leans heavily on x-ray and fluoroscopy, in which she is proficient. The electrocardiographic patterns are explained. Such specialized adjuncts as cardiac catheterization and radio-opaque substances are utilized as a clarification aid, with attention called to the fact that these special technics are difficult, intricate, and not readily available. Basic embryologic and physiologic principles are simply stated and then interwoven into the analysis of each malformation.

The author's descriptions, aided by many good illustrations and illustrative cases, are clear and logical. The two chapters on general medical care and surgical correction are worth while, especially

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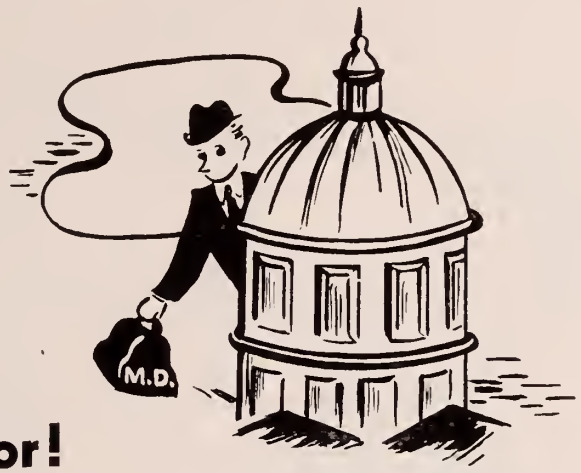

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★ SEE PAGE 647 FOR CURRENT ADVERTISERS.

the summary on surgical correction. Because of the recent development in surgery for the correction of congenital malformations of the heart, it is easy to see why exact diagnoses of cardiac anomalies are so important and so essential. The book is highly recommended not only to the pediatrician, surgeon, and internist, but to every physician.—H. H. S.

Minor Surgery. By Frederick Christopher, B. S., M. D., F. A. C. S., Associate Professor of Surgery at Northwestern University Medical School, Chief Surgeon, Evanston (Illinois) Hospital. Sixth Edition. Pp. 1058, with 937 illustrations on 595 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $12.00.

This is the sixth edition of this work in less than twenty years. This speaks well for the popularity of this volume and its acceptance by the profession at large. As pointed out by Doctor Christopher in the preface, it is difficult to distinguish between minor and major surgery; and an attempt is made in this volume to include that surgery of the general practitioner and of the physician who does not have ready access to a large hospital. There have been extensive revisions of many chapters, and new sections have been added. The sections on the use of antibiotics and the sulfonamides have been brought up to date. The use of anticoagulant therapy as well as femoral vein ligations in the treatment of thrombophlebitis and plebothrombosis have been revised. Also, the sections dealing with burns, varicose veins, artificial respiration, and pilonidal sinuses, have been revised. The use of gelatin sponges and oxidized cellulose in the control of hemorrhage, early postoperative ambulation, and refrigeration anesthesia are but a few of the new additions to this volume.

This book contains a wide variety of surgical information which is readily available to surgeons and general practitioners as the need arises.—K. E. L.

A Manual of Pharmacology; and Its Applications to Therapeutics and Toxicology. By Torald Sollmann, M. D., Professor Emeritus of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Seventh Edition. Pp. 1132. Philadelphia and London: W. B. Saunders Company, 1948. Price $11.50.

The timely appearance of this revision of one of the classic American textbooks of pharmacology again gives it preeminence in the field.

Extensive developments in the antibotics, sulfonamide, and other groups of drugs immediately before and during the war have led to such marked advancements in therapeutics and toxicology that earlier publications now are of limited usefulness. The latest proved procedures are included in this text.

Arrangement of the subject matter is such that material of greatest usefulness appears in ordinary type and data of special interest in small type have been continued. A two column page facilitates reading. The book is well composed and arranged. A unique but not distracting feature is the absence of chapter headings with direct continuation from one to another group of drugs. It would be a worth while addition to one's library.—O. S. O.

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Coming Events

American College of Chest Physicians

The fourteenth annual meeting of the American College of Chest Physicians will be held June 17–20 in Chicago, with headquarters in the Congress Hotel. There will be no registration fee, and all physicians are invited to attend.

Among other events on the program will be a symposium on streptomycin, a session on diseases of the chest, a section on miscellaneous topics, and the scientific assembly of the American Medical Association. Council luncheon meetings are scheduled for all four days, and round-table luncheons will be held Friday, Saturday, and Sunday. On Saturday, June 19, there will be the annual convocation at 6 p. m., to be followed by a social hour and annual presidents' banquet.

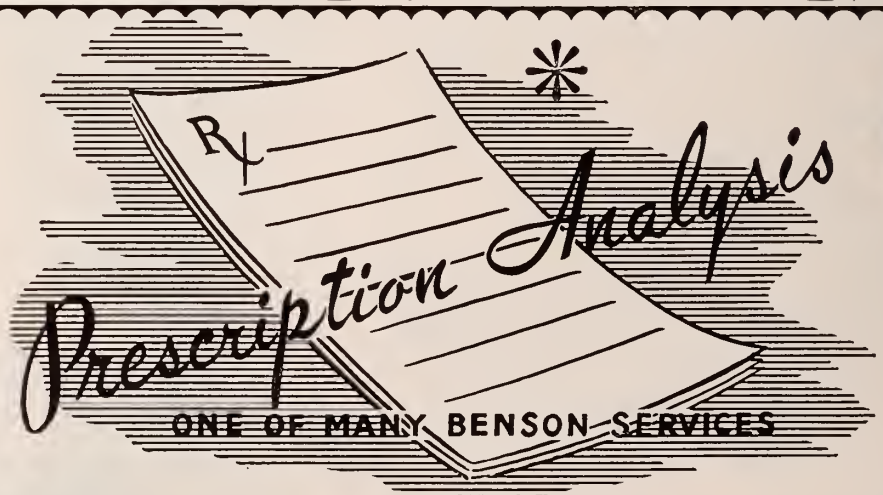
Clinics will be held from June 21 through June 23. On Monday the treatment of pulmonary tuberculosis with the use of the lung-immobilizing chamber will be demonstrated at Alexian Brothers Hospital. The pneumostat, a new apparatus for constant controlled pneumothorax, will be displayed at the Congress Hotel at 10 o'clock Tuesday morning, and there will be a Kodachrome clinic of anatomy and pathology of the tracheobronchial tree at the Educational Research Hospital of the University of Illinois at 2 o'clock Tuesday afternoon. A demonstration on BCG will be given in the amphitheater of the Cook County Children's Hospital at 11 a. m. Wednesday, and a television broadcast of a major surgical operation from Northwestern University Medical School will be presented at Navy Pier and Hotel Sheraton at 2 o'clock Wednesday afternoon.

Dinner For University of Pennsylvania Medical Alumni

University of Pennsylvania Medical Alumni will hold a dinner at the convention of the American Medical Association in Chicago on June 23 at the Lake Shore Club, 850 Lake Shore Drive. On arrival in Chicago, alumni are asked to contact Miss Frances R. Houston, executive secretary of the Medical Alumni Society, at the University of Pennsylvania registration booth.

First International Poliomyelitis Conference

Twenty international medical and scientific authorities will present papers on poliomyelitis at the First International Poliomyelitis Conference at the Waldorf–Astoria Hotel, New York, July 12–17. Following presentation of papers at each of the conference plenary sessions, the speakers will join with



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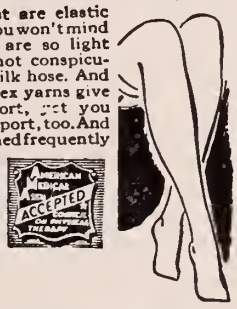

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a panel of authorities for an open discussion on particular phases of the disease. At one session, official government delegates, who have been invited from sixty-four nations, will present summaries on poliomyelitis problems in their homelands.

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American Congress of Physical Medicine

The American Congress of Physical Medicine will hold its twenty-sixth annual scientific and clinical session September 7–11 at the Hotel Statler, Washington, D. C. Scientific and clinical sessions will be presented each day, and all sessions will be open to members of the profession in good standing with the American Medical Association. The annual instruction courses will be held during the first four days. One set of ten lectures will be based primarily on physics and physiology, and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapists. Physical therapists must be registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physician Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

American College of Surgeons

The thirty-fourth Clinical Congress of the American College of Surgeons will be held in Los Angeles, with headquarters at the Biltmore Hotel, October 18–22. The program of scientific sessions on subjects in the fields of general surgery; eye, ear, nose, and throat surgery; gynecology and obstetrics; urology; and orthopedic, thoracic, plastic, and neurologic surgery will be supplemented by operative clinics in hospitals in Los Angeles and vicinity by showings of operations by television and motion pictures, and by a four day hospital standardization conference for hospital personnel. There will also be extensive technical and scientific exhibits.

At the Convocation which will be held on the final evening of the Clinical Congress, about 600 initiates will be received into fellowship. The College, which was organized in 1913 to elevate the standards of surgery, now has a total fellowship of more than 15,000 surgeons in North, Central, and South America and in a few other countries.

Dr. Donald G. Tollefson of Los Angeles is chairman of the Committee on Arrangements for the Clinical Congress.

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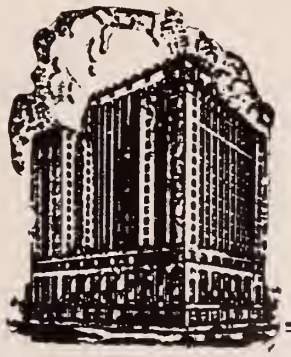

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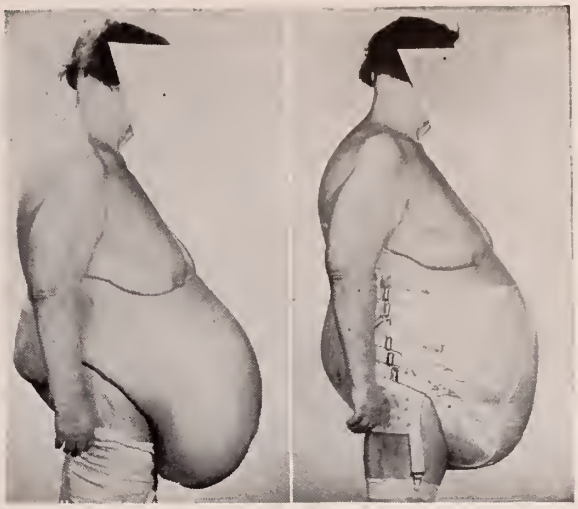
INDEX TO ADVERTISERS

	Page
Abbott Laboratories	566
Ames Company, Inc.	637
Ar-Ex Cosmetics, Inc.	630
Audiphone Utilities	646
Ayerst, McKenna & Harrison	570
Barr X-Ray Co.	645
Bellevue Place	630
Benson Optical Co.	642
Bergmann Prescription Pharmacy	627
Borden Co.	568
Camel (R. J. Reynolds Tobacco Co.)	560
Camp, S. H. & Co.	564
Central Drug	636
Ciba	563
Coca Cola Co.	640
Cook County Graduate School of Medicine	646
Doerflinger's	646
Endocrine Laboratories	557
First Central Dispensary	627
Hotel Schroeder	645
House of Bidwell, Inc.	645
Hurley X-Ray Co.	557
Ivanhoe Treatment, Inc.	638
Jensen Brothers	636
Kennedy–Mansfield Dairy	648
Lakeside Laboratories, Inc.	625
Lilly, Eli and Company	facing page 571
Lov-é Brassieres	633
M & R Dietetic Laboratories, Inc.	559
Mallatt Pharmacy	627
Mather Pharmacy	636
Mayer Drug	636
Mead Johnson & Co.	562, 650
Medical Protective Co.	651
Merck & Co., Inc.	565
Milwaukee Optical Co.	556
Milwaukee Sanitarium	652
New World Life Insurance Co.	623
New York Polyclinic	645
Orthopedic Appliance Co., Inc.	630
Parke, Davis & Co.	554, 555, 569
Physicians and Hospitals Supply	635
Physicians Casualty Assn.	646
Physicians Radium Assn.	645
Pogue, Mary E. School	646
Prescription Pharmacy	627
Radium Service Corporation	643
Rennebohm Drug Stores	627
Rentschler Floral Co.	648
Roemer's	643
Rogers Memorial Sanitarium	652
Sacred Heart Sanitarium	643
St. Croixdale Sanitarium	557
Schering Corporation	567
Schlintz Bros. Drug Store	636
Searle, G. D. & Co.	621
Shorewood Hospital Sanitarium	623
Smith–Dorsey Company	558
Spencer, Inc.	647
Summit Hospital	627
Swift and Company	631
Wander Co.	629
Webster–Chicago	637
Winthrop–Stearns, Inc.	561



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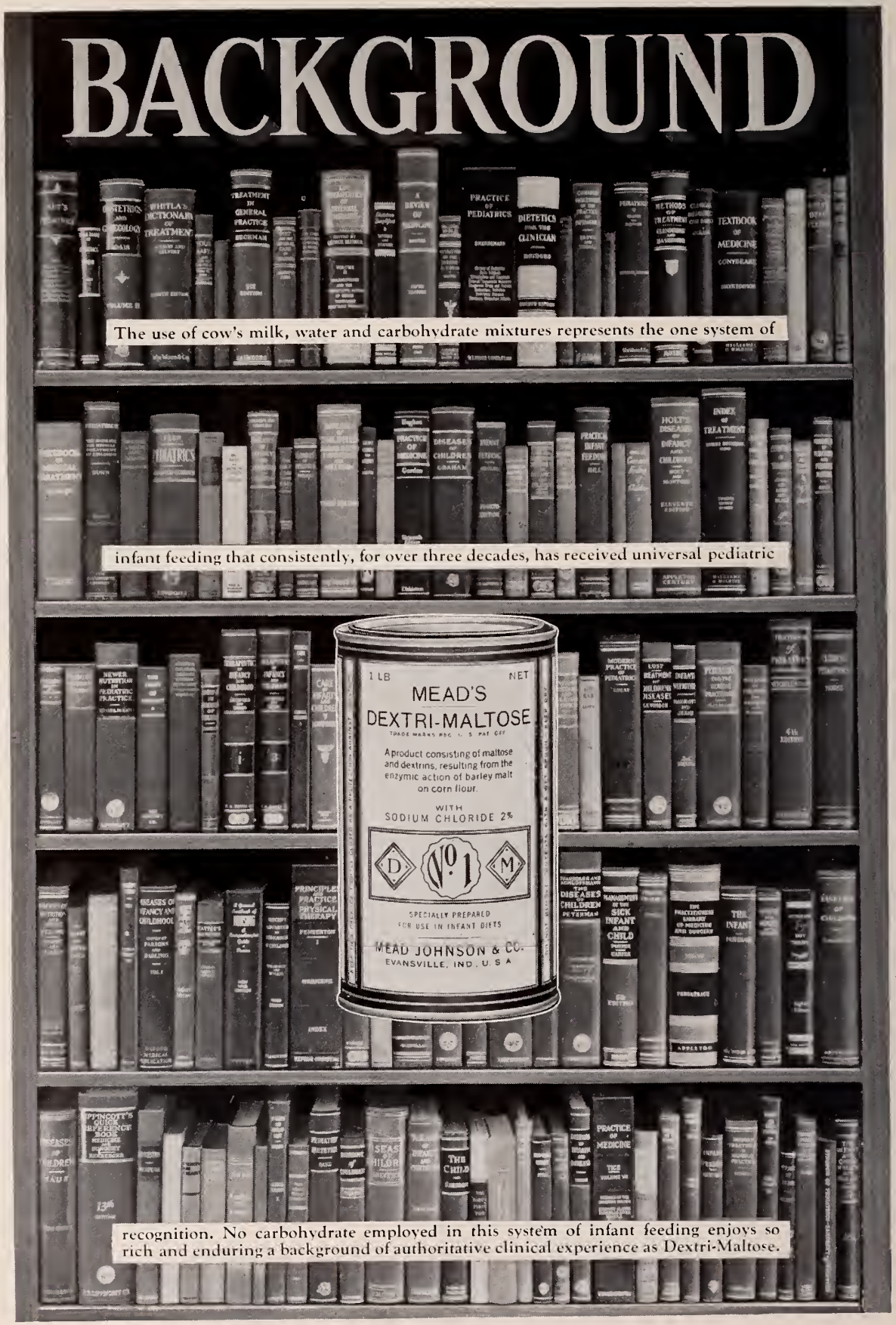
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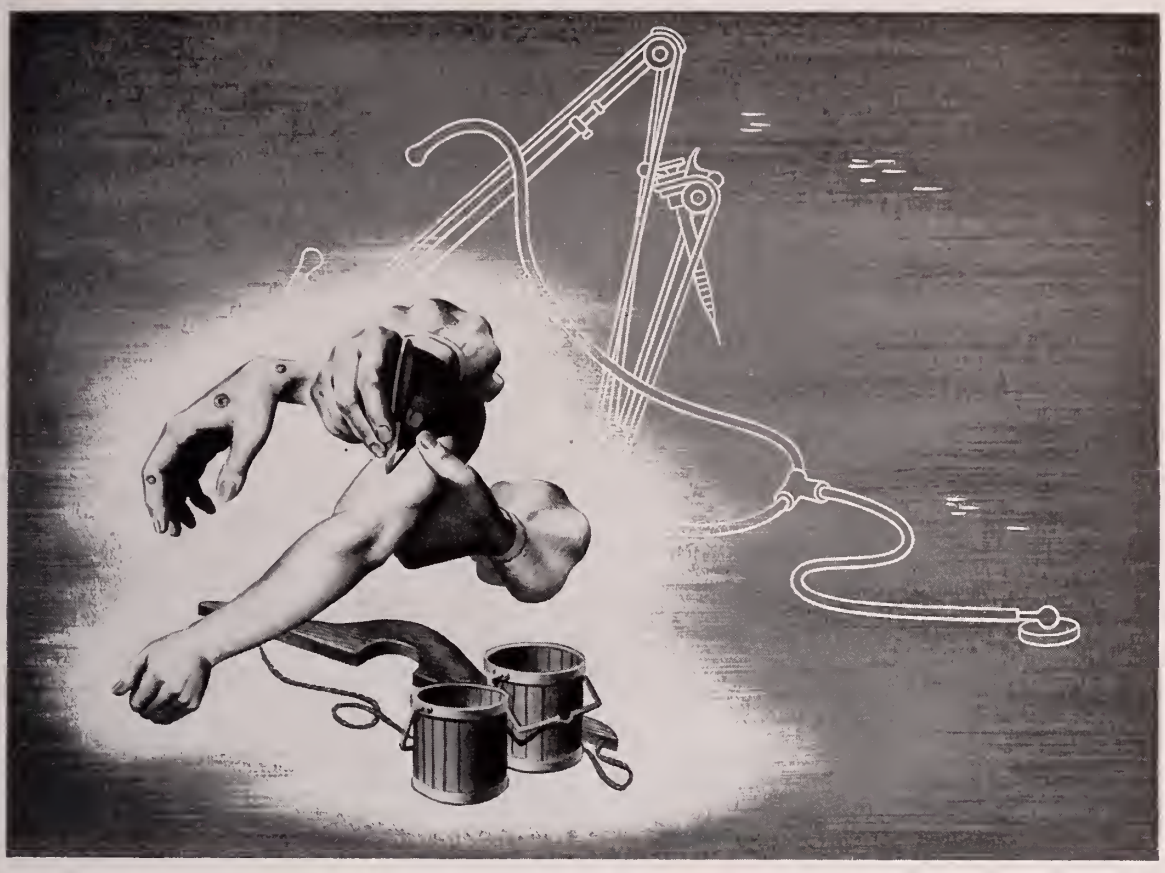

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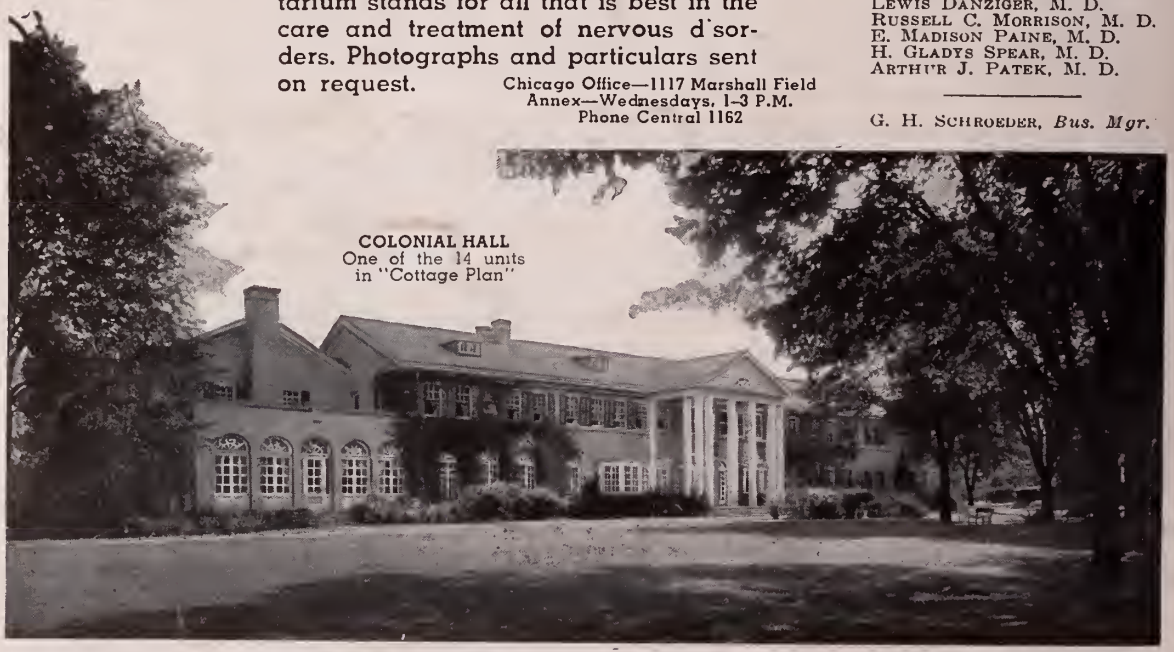

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
The Treatment of Subacute Bacterial Endocarditis with Penicillin and with Streptomycin, by John T. McCoy, M. D., and Ovid O. Meyer, M. D., Madison	671
The Treatment of Metastatic Bone Tumors, by Magnus I. Smedal, M. D., and Ferdinand A. Salzman, M. D., Boston	675
Some Thoughts on the Surgery of Retinal Detachment, by Derrick Vail, M. D., Chicago	687
Serology and Obstetrics, by R. T. LaVake, M. D., Minneapolis	690
The Management of the Nephrotic Syndrome in Chronic Glomerulonephritis, by A. W. Hilker, M. D., Eau Claire	693
Comments on Treatment	697
Notes on Clinical Pathology	698
As It Looks to Your State Board of Health	699

EDITORIAL

The Practitioner and the Diplomate, by J. C. Griffith, M. D., Milwaukee	

MISCELLANY

	Page
As It Looks from the Committee on Rural Medical Service of the American Medical Association	700
The President's Page	701
Annual Meeting Preliminary Announcement	704
Hotel Reservations for Annual Meeting	707
Society Proceedings	708
News Items and Personals	712
And About the Third and Twelfth Districts	714
Society Records	716
Marriage	718
Deaths	718
Correspondence	720
The Woman's Auxiliary	722
The Journal Bookshelf	730
Trade News	736
Physicians' Exchange	738
Index to Advertisers	740
List of Executive Officers of County Medical Societies	741

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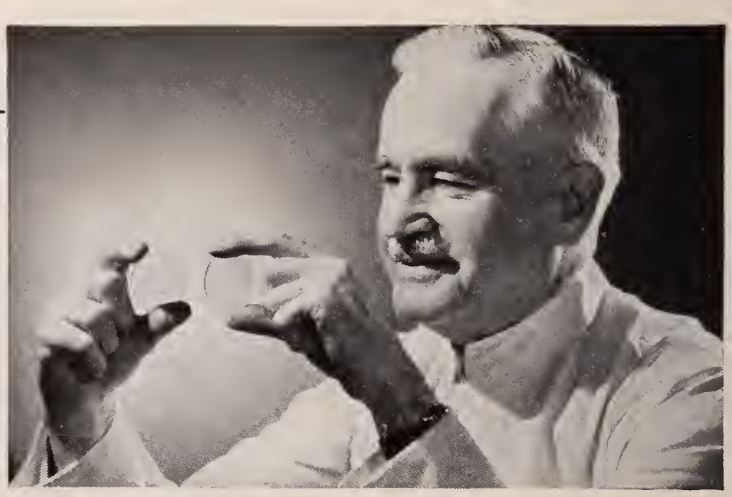

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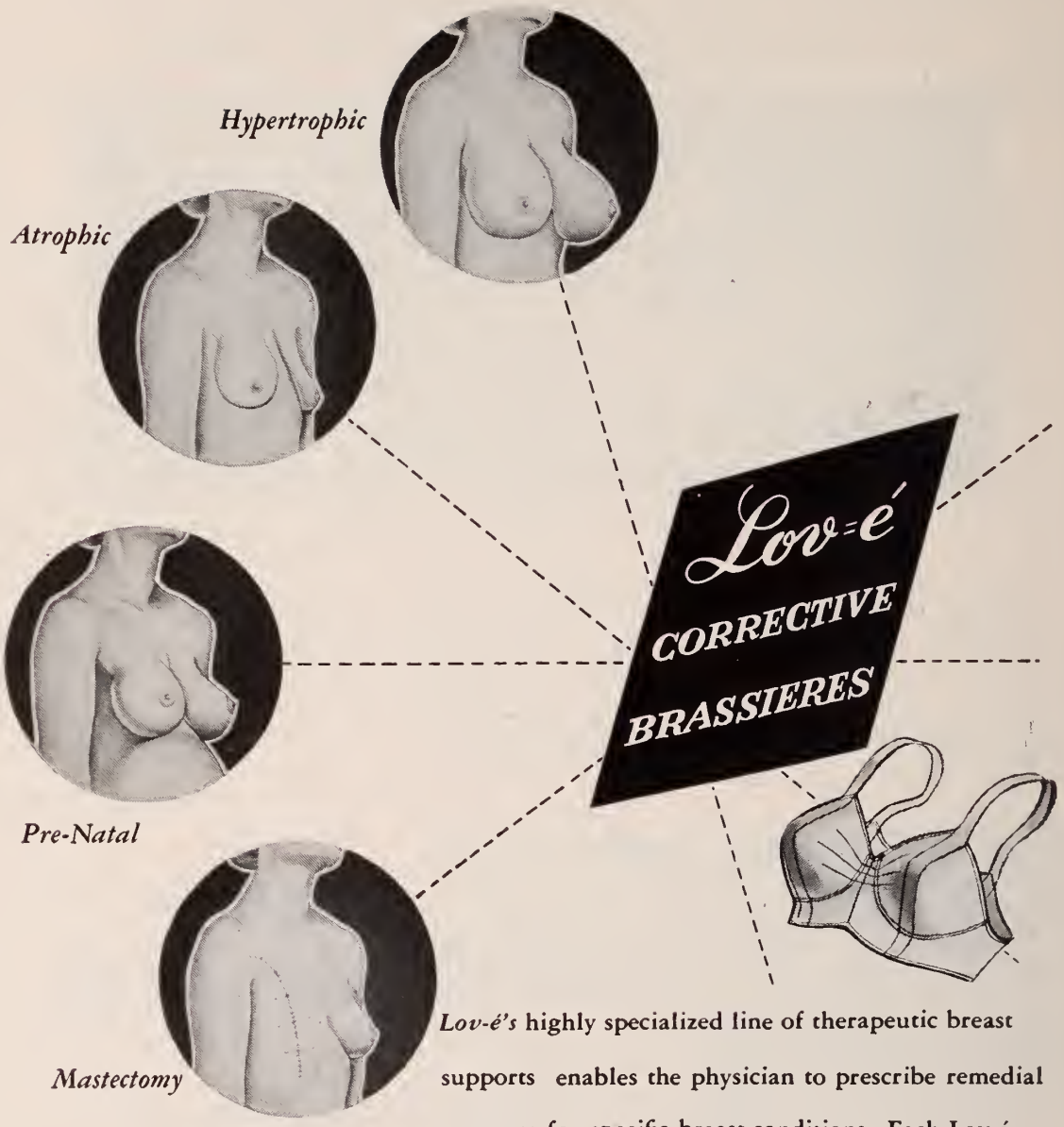

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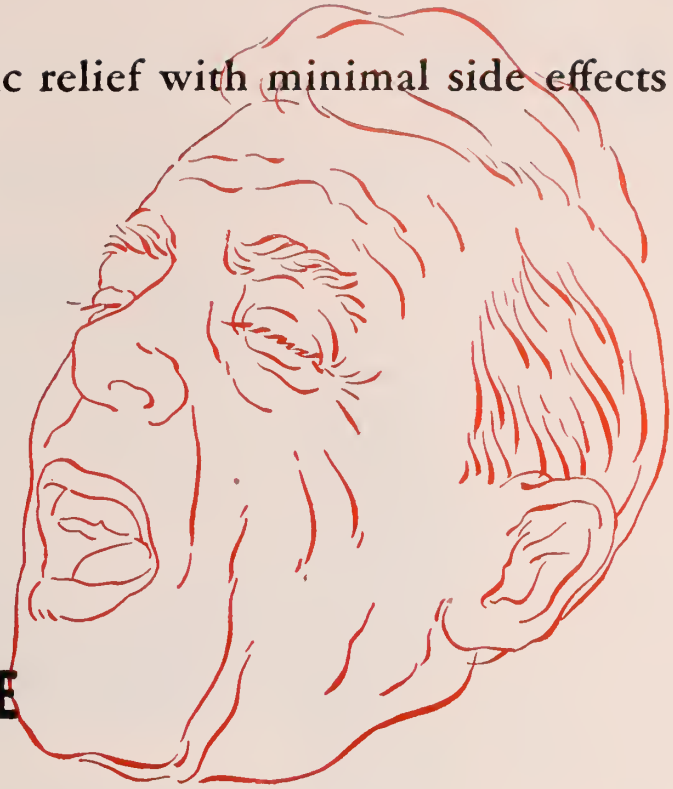

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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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[1] Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

[2] Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

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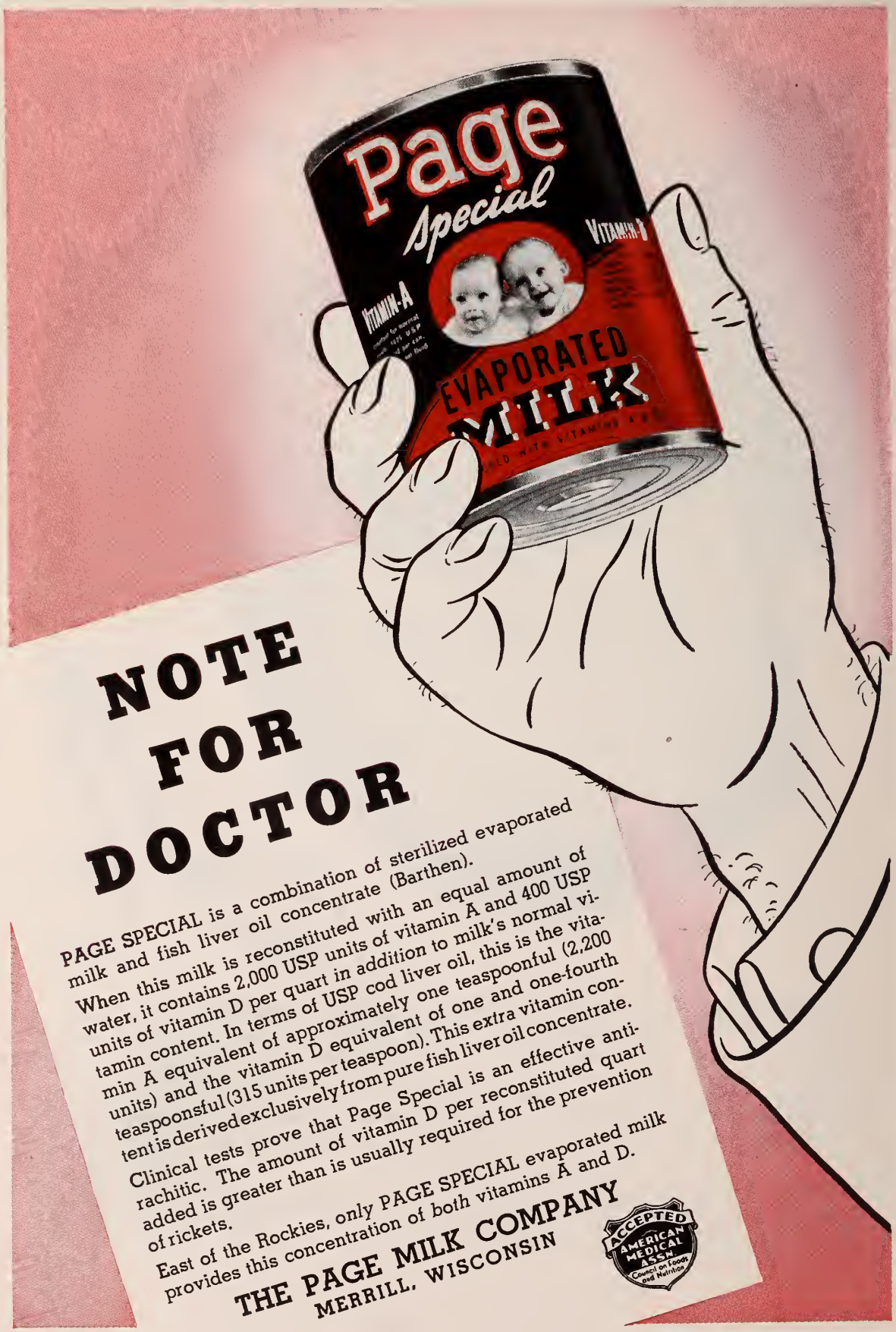
1. Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J.A.M.A. *133*:299, 1947 **2.** Robinson, H. M. and Robinson, H. M., Jr.: The Comparative Values of Some New Drugs in the Pyodermas, South. M. J. *40*:409, 1947 **3.** Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947 **4.** McCollough, N. C.: Treatment of Infected War Wounds with a Nitrofuran. Indust. Med. *16*:128, 1947.



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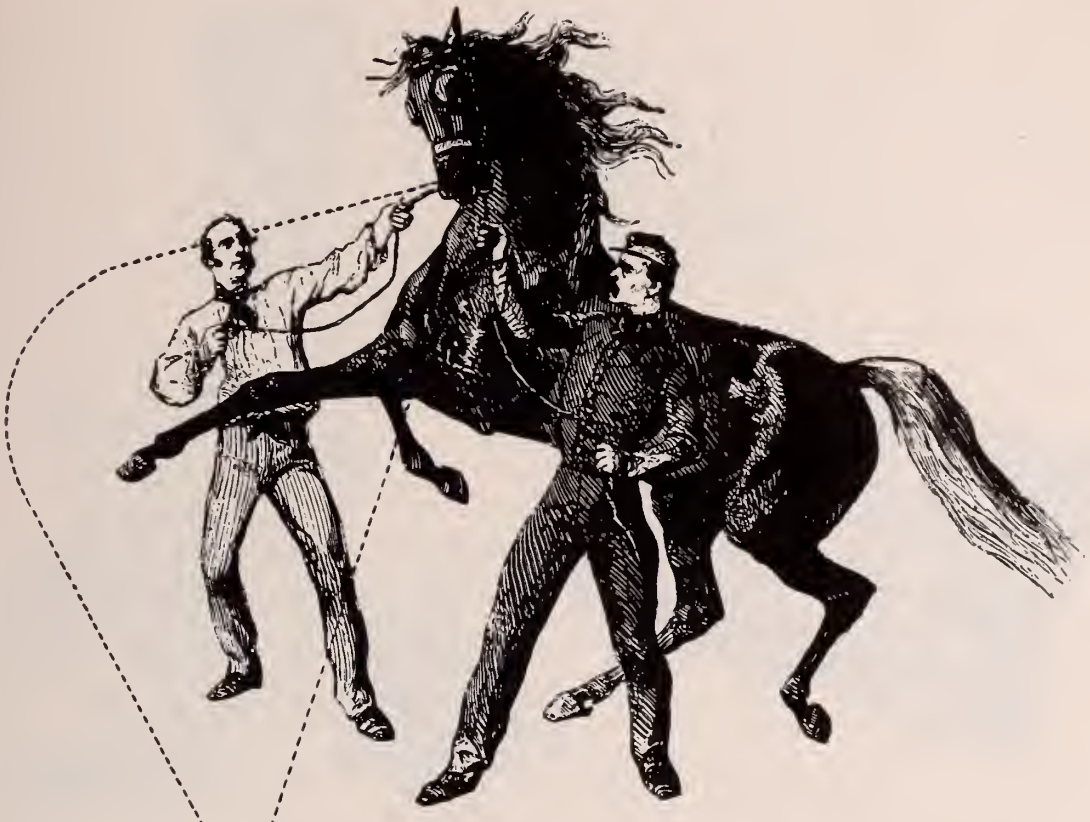

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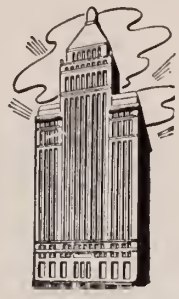

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THE WISCONSIN MEDICAL JOURNAL

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The Treatment of Subacute Bacterial Endocarditis with Penicillin and with Streptomycin*

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Doctor Meyer received his degree in medicine from the Columbia University College of Physicians and Surgeons in 1926. At present he is professor of medicine and chairman of the department of medicine at the University of Wisconsin Medical School.

THE analysis of the first 22 cases in which subacute bacterial endocarditis was treated at the State of Wisconsin General Hospital with penicillin and dicumarol or penicillin alone was reported by Thill and Meyer[1] in 1946. This study as well as that of Priest[2] and others resulted in the conclusion that there was no definite advantage from using an anticoagulant with penicillin over penicillin alone in the treatment of this disease and that there were definite hazards from the use of the dicumarol. Streptomycin has since become available and has been found to be the drug of choice in certain cases of this disease in which the causative organism is resistant to penicillin. Since the above study was published, an additional 12 patients have been treated, 8 with penicillin and 4 with streptomycin. None of these patients received an anticoagulant. The complete series of 34 cases is here reviewed in detail.

In this series there were 20 males and 14 females. Fifteen of the males and 7 of the females recovered from their infection. The ages of these patients varied from 13 to 76, with 92 per cent under 60 years of age. Of the patients under 60 years of age, 70 per cent recovered from their infection, while only 50 per cent of those over 60 recovered. Thirty, or 93 per cent, of these patients were diagnosed as having rheumatic heart disease, 2 patients were thought to have congenital heart disease, and 2 presented the symptoms and findings of a combination of rheumatic and congenital heart disease.

The duration of symptoms before the diagnosis had been made varied from two weeks to eighteen months. There were 10 of less than six weeks', 8 of six weeks' to three months', 7 of three to six months', and 9 of six months' or longer duration. Of the group with symptoms of less than three months, 72 per cent recovered, and of those with symptoms of over three months 56 per cent recovered. This finding differs from that of Thill and Meyer,[1] who found no clearcut evidence that it was more difficult to treat patients with long-standing symptoms than those with more recent infections, and it agrees with the impression of Jones, Herring, *et al.*[3] that with early diagnosis and prompt treatment the present mortality should be materially reduced.

The causative organism was identified in all of the cases reviewed. It was found to be alpha hemolytic Streptococcus in 73 per cent of the cases and nonhemolytic Streptococcus in 12 per cent, and in 1 case each (3 per cent) the organism was Pneumococcus, Neisseria subflava, Corynebacterium (type not identified), Hemophilus influenzae, and Escherichia coli.

Table 1 gives a comparison of the results with various amounts of penicillin used. Thus, considering 5,000,000 units as a minimum dosage as a course of penicillin to be used in the treatment of a patient with subacute bacterial endocarditis, 78 per cent of

* This study was aided in part by a grant for technical assistance from the Lakeside Laboratories, Milwaukee.

the patients receiving this amount of the antibiotic recovered from their disease. (In some cases the patient expired before the minimum course was completed.)

TABLE 1.—*Amounts of Penicillin with Results in Treatment of Subacute Bacterial Endocarditis*

Amount of Penicillin	Patients, No.	Recoveries, No.	Recoveries, %
Less than 1,000,000 units*	4	0	0
1,000,000– 5,000,000	7	4	57
5,000,000–10,000,000	7	7	100
10,000,000–20,000,000	3	1	33
20,000,000–40,000,000	4	3	75
40,000,000–60,000,000	1	1	100
60,000,000+	4	3	75
5,000,000 or more	19	15	79

*Usually small dosage because of death of patient before therapy complete.

Table 2 presents an evaluation of the results of therapy according to its duration. Assuming six weeks to be a satisfactory minimum period of therapy, 17 of the 18 patients having treatment of this duration recovered from their infection. In 22 of this series of the 34 cases, or 66 per cent, the condition was considered to be arrested. This figure of 66 per cent is the same as the average figure reported by Jones, Herring, *et al.*[3] in their summary of cases reported between January 1945 and August 1946.

TABLE 2.—*Duration of Therapy (Penicillin) in 30 Cases of Subacute Bacterial Endocarditis*

Duration	Patients, No.	Recoveries, No.	Recoveries, %
4 wk. or less*	9	0	0
4–6 wk.	3	2	66
6–8 wk.	7	7	100
8 wk.+	11	10	90
6 wk. or more	18	17	94

*Therapy not continued because of death of patient, or the patient left hospital against advice.

Follow-up study was available on 19 of the 22 patients discharged as having the disease arrested. From table 3 it can be seen that 18 out of the 19 were alive two or more months after discharge. The 1 patient who expired died of congestive heart failure several months after discharge and was found at autopsy to have healed vegetations of the tricuspid valve. Twelve of the 19 cases were followed for six months or longer.

TABLE 3.—*Follow-Up Studies in 19 Cases of Subacute Bacterial Endocarditis Treated with Penicillin or Streptomycin*

Died: 1	
Living: 18	
2 mo.	3
2–6 mo.	3
6–12 mo.	4
12–18 mo.	3
18–24 mo.	3
24+ mo.	2

Eighteen out of 19 had follow-up of two months or more (95 per cent.) Data on 3 additional arrested cases were not available.

It was noted in this study that the mortality was nearly twice as great for those patients that had received previous chemotherapy or antibiotic therapy before our treatment of the subacute bacterial endocarditis was instigated. Forty-six per cent of the 15 patients having previous therapy before entry into the hospital expired, as compared with 26 per cent of the 19 patients not having previous treatment. This finding seems to correlate well with the impression of Thill and Meyer[1] that there was greater effectiveness of therapy in those patients that had not received previous therapy.

In 2 cases in this series in which the organism was found to be moderately resistant to penicillin, caronamide (Staticin) (4-carboxyphenylmethanesulfonanilide) was used in order to increase the penicillin blood levels. Studies by Beyer[4,5] have indicated that this drug acts against tubular excretion although not against tubular reabsorption. From their studies it was concluded that substances that were excreted primarily by the tubules could be maintained in the blood stream at higher concentrations for longer periods of time by the use of caronamide. Their studies showed decreased excretion of phenolsulfonphthalein, para-amino hippuric acid, and penicillin when oral caronamide was added. In 1 of our 2 cases the drug was discontinued because of a febrile reaction plus a skin rash. The successful use of this adjunct to penicillin therapy is illustrated by the following case of a 66 year old white male:

CASE J. B.—The patient was admitted with a history of profound weakness associated with an evening fever, anorexia, weight loss, night sweats, and transient early morning headaches of five weeks' duration.

Past medical history was noncontributory except for the extraction of two "bad teeth" two months before the onset of the illness. There were no symptoms referable to the cardiorespiratory system.

Physical examination revealed the signs of a double mitral lesion of the heart, but was otherwise negative except for a temperature of 102 F., and a coarse tremor of the hands and tongue.

Laboratory Studies.—Urinalysis showed albumin, 0 to 0.5 Gm. per hundred cubic centimeters, and varying amounts of pus cells. Blood studies showed hemoglobin 12.7 Gm. per hundred cubic centimeters, erythrocytes 4,250,000, and leukocytes 11,700, with 81 per cent polymorphonuclears. Blood cultures were positive for alpha hemolytic Streptococcus. This organism was found to be sensitive to 0.1 unit per cubic centimeter of penicillin.

The patient was given 50,000 units of penicillin every three hours intramuscularly for seventeen days. Penicillin serum levels of 0.2 unit per cubic centimeter were obtained. The dosage was increased to 60,000 units every three hours for eleven more days. The three hour serum level continued to remain about 0.2 unit per cubic centimeter. The dosage was increased to 100,000 units every three hours for a final fourteen days and then stopped.

A blood culture taken the day before the penicillin was discontinued and reported several days later was positive for alpha hemolytic Streptococcus. This organism was found to be inhibited by 0.6 unit per cubic centimeter of penicillin.

Therapy was resumed with 100,000 units of penicillin every three hours and a serum level of 0.2 unit per cubic centimeter was obtained. Three days

later caronamide, 1.5 gm. every three hours, orally was started. A serum level at the end of three hours was found to be 0.5 unit per cubic centimeter. The penicillin was increased to 200,000 units every three hours for seventeen days. Three hours after a dose, serum levels of 0.75 unit were noted and one hour levels of 4 units per cubic centimeter were obtained. Blood cultures continued to be negative during and after this course of therapy. On re-examination ten months later there were no signs of recurrence of his infection, and blood cultures remained negative.

In the last two years streptomycin has been used in certain cases of subacute bacterial endocarditis in which the causative organism was not sensitive to penicillin. Usually this was a gram-negative organism. Of our 4 patients, 3 recovered from their infection, and the fourth, who entered the hospital in the terminal phase of her disease, received treatment for only ten days because of the apparent ineffectiveness of the therapy. From table 4 it can be seen that the dosage in the successful cases varied from 48 to 192 Gm. of streptomycin and the duration of therapy from twenty-four to fifty-two days. The case of R. D. presents some interesting aspects of this form of treatment.

TABLE 4.—*Patients Treated With Streptomycin*

Case	Organism	Streptomycin Dosage, Total	Duration	Sensitivity of Organism	Levels Maintained	First Negative Culture	Remarks
Case 1 L. L.	Neisseria subflava	192 Gm.	52 days	0.5 microgram /cc.	10–35 micrograms /cc.	1 day	Had cholecystectomy; 3 mo. check-up o.k.
Case 2 C. K.	E. coli	22 Gm.	10 days	1,000 micrograms /cc.	None Recorded	None	Patient expired
Case 3 D. A.	H. influenzae	48 Gm.	24 days	0.6 microgram /cc.	2.4–10 micrograms /cc.	4 days	Toxic symptoms; improved on check-up; follow-up 10 mo.
Case 4 R. D.	Corynebacterium	117 Gm.	42 days	5 micrograms /cc.	10–23 micrograms /cc.	7 days	Toxic skin manifestations

CASE R. D.—The patient was a 28 year old white male with a history of rheumatic fever at the age of 14 with a recurrence at the age of 16. Although the patient had been doing hard manual labor, he had had no symptoms until eight months before admission. At that time he had migratory joint pains, low grade fever, and night sweats. In the intervening period until his hospital admission he had lost 20 pounds in weight, had palpitation, and dyspnea on exertion. Two weeks before admission he had abdominal cramps and a sharp pain in the left upper quadrant.

Physical examination revealed emaciation, pallor, petechiae of the lower extremities, cardiac enlargement, signs of a double mitral lesion, an aortic systolic murmur, blood pressure of 110/60, spleen palpable 2 cm. below the left costal margin, and liver palpable 3 cm. below the right costal margin.

Laboratory Studies.—Urinalysis showed albumin, 0.08 Gm. per hundred cubic centimeters, occasional red blood cells, and casts. Blood studies revealed hemoglobin 9.25 Gm. per hundred cubic centimeters, erythrocytes 3,860,000, and leukocytes 7,300 with 14 per cent filamented and 46 per cent nonfilamented neutrophiles, 27 per cent lymphocytes, 12 per cent monocytes, and 1 per cent basophiles. Nonprotein nitrogen and blood sugar were normal. Repeated blood cultures revealed a Corynebacterium, which was inhibited by 1 unit per cubic centimeter of penicillin and by 5 micrograms per cubic centimeter of streptomycin.

The patient received 0.5 Gm. of streptomycin intramuscularly every three hours. A serum streptomycin level of 23 micrograms per cubic centimeter was obtained in the three hour specimen. The temperature returned to normal twenty-four hours after the treatment was instigated. On the ninth day of treatment a toxic skin rash, gynecomastica, and fever developed. The dosage was changed to 0.25 Gm. every three hours intramuscularly, and another preparation of streptomycin was used. Following these changes the patient felt improved, the rash disappeared, and the temperature returned to normal. The dosage was gradually decreased, but a minimum three hour serum level of 8 micrograms per cubic centimeter of streptomycin was maintained. Streptomycin was continued for a total of forty-two days and a total of 117 gm. was given. During and following therapy the blood cultures were negative. The patient experienced vertigo and after the twenty-seventh day of therapy the caloric tests for vestibular function showed no response. The hearing tests done during the course of treatment showed a gradual decrease of the auditory acuity throughout the whole range in the left ear and a loss of the higher frequency tones in the right ear. Re-examination four months after discharge showed no recurrence of the infection, and blood cultures remained negative.

Discussion

Previous to the use of antibiotics, only a very occasional patient with subacute bacterial endocarditis recovered in this hospital. Although 1 patient treated with x-ray therapy and another with sulfadiazine treatment did recover from their infection, these forms of treatment were usually not satisfactory. The use of the antibiotics, especially penicillin, has definitely changed this picture.

From our observation we have arrived at certain seemingly justifiable conclusions. For the proper handling of patients with subacute bacterial endocarditis, three requirements must be met: adequate bacteriologic studies, determination of the sensitivity of the offending organism to the antibiotics, and, following the instigation of therapy, frequent evaluations of the blood serum level of the antibiotic

used in the treatment. We believe that the serum level of the antibiotic should be at least twice, and preferably four to five times, that required to inhibit the growth of the organism in a test tube.

It is our usual plan for treatment in a case of subacute bacterial endocarditis in which the organism has been isolated and found to be sensitive to penicillin to begin treatment with 50,000 units of penicillin intramuscularly administered every three hours. (There are many who favor administration every two hours.) At the end of the second day of treatment, measurement of the penicillin level at the end of three hours after the last injection is made (method of fractional dilutions). The dosage is then either maintained or increased, as necessary, to maintain serum levels of two or more times the *in vitro* sensitivity of the organism. Penicillin serum levels are determined twice a week, and the therapeutic level is maintained for a minimum of six weeks. Blood cultures using penicillinase are taken daily for the first few days after the beginning of the treatment and then once a week during the treatment as well as every other day for one week after discontinuing the treatment. Finding a positive blood culture during treatment demands redetermination of the sensitivity of the organism and more intensive therapy. We request the patient to return at the end of one month after discharge for re-examination and three blood cultures. Following this we like to recheck the patients with blood culture studies every three months, for the first year and then every six months.

We believe that any patient with rheumatic or congenital heart disease who is to be subjected to operation where organisms may enter the blood stream, especially oral surgery, should have a course of prophylactic treatment with either sulfadiazine or penicillin. The sulfadiazine treatment consists of 1.0 Gm. of sulfadiazine four times a day for three days before and for four days after the procedure. The penicillin treatment which has been advocated consists of 50,000 units intramuscularly one-half hour before the procedure, another 50,000 units immediately following the procedure, and then 25,000 units every three hours for six days. With the advent of procaine penicillin (Duracillin),[6] a suitable prophylaxis may consist of 300,000 units of the procaine pencillin in sesame oil daily for thirty-six hours before and for five days after the procedure.

Summary

1. Thirty-four cases in which subacute bacterial endocarditis was treated with antibiotics—30 with penicillin and 4 with streptomycin—are here reported.

2. Seventy-two per cent of these patients with symptoms of less than three months' duration recovered, as compared to a 56 per cent recovery rate in those with symptoms of more than three months.

3. Sixty-six per cent of all the patients with subacute bacterial endocarditis treated with antibiotics recovered.

4. Follow-up studies of six months or longer showed 12 of 19 patients with no signs of recurrence of the infection.

5. Caronamide (Staticin) was used in 2 cases, discontinued in 1 because of a toxic reaction and successfully employed in another.

6. A method of treatment of subacute bacterial endocarditis and a method for prophylaxis are suggested.

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WISCONSIN STATE MEDICAL GOLF ASSOCIATION

The Wisconsin State Medical Golf Association will hold its tournament at the Maple Bluff Country Club, Madison, on July 21. Dr. Albert Tormey, Madison, is general chairman in charge of the event, and Dr. Waldo Dimond is assistant chairman. All entries should be sent to Dr. H. L. Greene, Chairman of the Golf Committee, in care of the Maple Bluff Country Club. The following physicians will serve on committees: Drs. H. L. Greene, chairman, George Ewell, M. J. Musser, M. T. Morrison, and Aagnar Smedal on the Golf Committee; Drs. Stuart McCormick, chairman, J. S. Supernaw, J. A. Hurlbut, Eugene Juster, and John Waddell on the Prize Committee; Drs. Ken Lemmer, chairman, Gunnar Quisling, J. E. Dollard, and S. A. M. Johnson on the Entertainment Committee; W. B. Dimond, chairman, George Stebbins, and J. C. Dean on the Dinner Committee.

The Treatment of Metastatic Bone Tumors*

By MAGNUS I. SMEDAL, M. D. and FERDINAND A. SALZMAN, M. D.
Boston

M. I. SMEDAL

A native of Wisconsin, Doctor Smedal graduated from the University of Wisconsin and Harvard Medical School. After practicing for a brief period in Viroqua, he entered a residency at Boston City Hospital and later established a private practice in Boston. He has been on the staff of the New England Baptist Hospital, Boston, since 1933 and a member of the Department of Radiology of the Lahey Clinic since 1940. He is a member of the American College of Radiology.

F. A. SALZMAN

Doctor Salzman received his medical degree from the Long Island College of Medicine in 1942. After interning at Englewood Hospital, Englewood, New Jersey, he entered the Army. Following his discharge, he accepted a position in the medical department of a pharmaceutical house. He now has a fellowship in radiology at the Lahey Clinic in Boston.

WE ARE presenting a follow-up on the diagnosis, treatment, and survival of patients in 100 consecutive cases of bone metastases seen at the New England Baptist Hospital from 1940 to 1947. We thought it would be of interest to take consecutive cases, classify them according to the site of the primary lesion, and discuss them in terms of pathologic type, origin, and end results, since most of us treating patients with cancer are concerned primarily with knowing the fate of patients with the most commonly occurring tumors (tables 1 and 2).

Since the advent of hormonal and radioactive therapeutic methods, the treatment of metastatic lesions is in a state of change, and due regard to these newer methods will be given under the groups as they are discussed. The tried methods of therapy, that is, irradiation and surgery, will be discussed generally for all types of metastatic bone lesions.

In the discussion, lymphomas and leukemias have been omitted. Primary bone tumors with metastasis to bone have also been passed over, since in the literature the majority would be metastases from Ewing's sarcoma and many writers feel that these are a generalized manifestation of a systemic disease.

TABLE 1.—*Sites of Lesions in 100 Consecutive Cases of Metastatic Bone Tumors*

	Total Cases	Skull	Spine	Pelvis	Rib	Femur	Sternum	Humerus	Scapula	Clavicle
Prostate	29	0	25	19	9	3	0	0	1	0
Breast	24	4	20	10	18	5	2	2	3	1
Rectum	6	1	5	0	1	0	0	0	0	0
Kidney	4	0	2	1	3	1	0	1	0	0
Lung	4	2	2	1	3	2	0	0	0	0
Stomach	3	1	1	1	3	1	0	0	0	0
Urinary bladder	3	0	1	2	1	0	0	0	0	0
Thyroid	2	0	2	1	0	0	0	0	0	0
Transverse colon	1	0	0	0	0	0	0	0	0	1
Descending colon	1	0	1	0	0	0	0	0	0	0
Sigmoid	1	0	1	1	0	0	0	0	0	0
Esophagus	1	0	1	0	0	0	0	0	0	0
Pancreas	2	0	1	0	1	1	0	0	0	0
Lymphatic leukemia	1	0	0	1	0	1	6	0	0	0
Lymphoma	1	0	1	0	0	0	0	0	0	0
Unknown	17	3	12	4	5	4	0	2	0	0

TABLE 2.—*Type of Lesion in 100 Consecutive Cases of Metastatic Bone Tumor*

	Lytic Lesions	Blastic Lesions	Mixed Lesions	Pathologic Fractures
Prostate	0	21	8	2
Breast	16	1	7	3
Rectum	4	1	1	0
Kidney	4	0	0	0
Lung	2	0	2	1
Stomach	1	1	1	0
Urinary bladder	3	0	0	0
Thyroid	2	0	0	0
Transverse colon	1	0	0	1
Descending colon	0	1	0	0
Sigmoid	1	0	0	0
Esophagus	1	0	0	0
Pancreas	2	0	0	0
Lymphatic leukemia	1	0	0	0
Lymphoma	1	0	0	0
Unknown	12	3	2	3
Total	51	28	21	10

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

Table 3 is a compilation from the literature on the incidence of skeletal metastases from various primary sites. It will be evident that, from a statistical view, the most frequent metastases are those arising from carcinoma of the female breast, prostate, kidney, thyroid, and lung. The figures from Toumey are clinical in origin, while the others are derived from autopsy material. The series from Geschickter and Copeland is from an earlier period than the others, and their lower figures probably reflect the less extensive use of roentgenography for locating metastases to bone at that time. The metastases from grades II and III lesions are more frequently relieved by irradiation. The duration of relief and longevity after occurrence, however, is greater in patients with the lower grades of primary lesions. Burch also stated that after metastases have existed for ten months or more, there is little effect from irradiation. Conversely, in 35 of 38 patients treated within six months after the onset of bone metastases, as manifested by pain, there was some palliation in all grades.

Bouchard is optimistic as long as only the bones are involved in metastases, stating that they are

TABLE 3.—*Incidence of Skeletal Metastases Compiled from the Literature*

Primary Site	Geschickter and Copeland (autopsy material)	Turner and Jaffe (autopsy material)	Toumey (clinical)	Freid	Warren (autopsy material)
Breast carcinoma	100, or 5.2%, of 1,914 89, or 11.8%, of 757	60, or 57.1%, of 105	42, or 12.9%, of 326		69, or 42.6%, of 162
Prostatic carcinoma	134, or 12.9%, of 1,040	55, or 57.8%, of 95	11, or 7.8%, of 140	35, or 58%, of 60	
Cervical carcinoma	2, or 2.3%, of 86	8, or 8%, of 99			5, or 3.8%, of 132
Uterine carcinoma	3, or 3.5%, of 86	0 in 32 cases	2 cases		
Thyroid carcinoma	16, or 27.7%, of 238*	3, or 37.5%, of 8	3, or 1.9%, of 160		
Bronchogenic carcinoma	4, or 16.6%, of 24	8, or 24.2%, of 33	1 case		
Hypernephroma	22, or 34.9%, of 63	5, or 20%, of 25		39, or 45%, of 87	
Ovarian carcinoma	2, or 2.8%, of 69	1, or 6%, of 17			
Melanoma	3, or 1.8%, of 169	7, or 43.7%, of 16			
Carcinoma of colon	Single case in cecum, sigmoid and rectum	21, or 11.1%, of 188	1 case in 1,350 gastrointestinal malignancies		0 in 156
Carcinoma of stomach	7, or 1.3% of 537	8, or 7.4% of 107	1 case in 1,350 gastrointestinal malignancies		
Carcinoma of bladder	1 case	6, or 13%, of 46		3% (From Registry of Urological Association)	

*From Ehrhardt, O., Ref. 11.

report by Turner and Jaffe in this connection is extremely interesting and illuminating. Not shown on table 3 is a statement that in 1,302 autopsies on patients who died of carcinoma, 18.4 per cent showed bone metastases and 26.6 per cent had pulmonary metastases. Bone metastases without concomitant lung metastases occurred in 104 cases. The figures from Turner and Jaffe are constantly higher than those from other sources. Of interest to us is their from Turner and Jaffee are constantly higher than figure of 21, or 11.1 per cent, of 188 cases of carcinoma of the colon and 8, or 7.4 per cent, of 107 cases of carcinoma of the stomach with bone metastases. In Warren's 42 series of 156 autopsies in cases of carcinoma of the colon, there were no bone metastases. The discrepancy must lie in the completeness of radiologic bone survey.

Metastases from Cancer of the Breast

The incidence of bone metastases from carcinoma of the breast is, according to Burch, the same as the incidence of occurrence both as to the age of the patient and as to the grade of the tumor. The time of appearance of bone metastases, he stated, is much earlier in the age group of 20 to 30 years, the average time of onset being one-half that of the group as a whole. The grade of the tumor is important because the higher grades of primary lesions metastasize proportionately earlier. The extent of the bone lesions and the roentgenologic appearance have no relation to grade. Evidence of healing takes place in all grades after x-ray therapy, but patients with involved in 62 per cent of cases before other organs are involved and that under such conditions the prognosis may reach an expectancy of thirty-three months. Bouchard stated that the pelvis is involved in 75 per cent of cases of bone metastases, the lumbosacral spine in 71 per cent, ribs in 71 per cent, dorsal spine in 62 per cent, femur in 54 per cent, cervical spine in 33 per cent, skull in 25 per cent, and scapula in 25 per cent. None occurred below the knee or elbow. According to Burch, the tenth dorsal vertebra is the bone most frequently involved.

In our series there were 24 patients with carcinoma of the breast (table 1), 1 of whom was a man. This group (24 per cent) constitutes the second largest group in these 100 cases of skeletal metastases. The skeletal lesions were preponderantly lytic in type (16), with 7 showing mixed lesions on the roentgenograms. The patient in 1 case showing blastic lesions was a 66 year old man who had involvement of the pelvis, sacrum, both femora, and several ribs.

The spine was the most frequent site of metastases (20 cases), with equal frequency between dorsal and lumbar vertebrae, and the ribs were involved in 18 patients. There were three pathologic fractures, involving the pubic ramus, rib, and femur. The skull was the site of metastases in 4 cases. The pelvis was involved in 50 per cent of the cases; however, in our tabulation we included the sacrum (involved in 5 cases) under the spine category.

In 15 cases the onset of metastases postoperatively occurred on an average of twenty-eight months; 8

other patients showed metastases at the time of first examination. Of 11 patients who died, the interval from onset of metastases to death averaged fifteen and seven-tenths months, with a distribution of one to ninety-two months. This is a somewhat higher survival following metastases than some authors report. We have never seen osteolytic lesions after the menopausal age.

Treatment—Irradiation has been the only good method for palliation, and that is all that has been achieved to date by any method. Table 4 illustrates representative series from the literature on both the time of appearance of metastases after radical mastectomy and the interval between the onset of metastases and the death of the patient. Burch's cases are classified into those with involvement and those without involvement of axillary nodes at the time of operation and show how strikingly different the prognosis becomes in the two groups. The other authors are in close agreement that an average of thirty months elapses in all cases between the date of radical mastectomy and the appearance of bone metastases.

TABLE 4.—*Prognosis in Metastases to Bone from Carcinoma of Breast*

	Time of Appearance Postoperatively	Interval from Onset of Metastases to Death
Burch	With axillary nodes, 16.9 mo. Without axillary nodes 47.9 mo.	15.5 mo.
Bouchard	All cases, 45.3 mo. exclusive of 2 unusual cases, 34.0 mo.	*Group I — 7.4 mo. Group II —15.2 mo. Group III—14.6 mo.
Geschickter and Copeland	All cases, av. 30 mo.	With x-ray therapy, 10–18 mo. Without x-ray therapy, 7–11 mo.
Toumey	All cases, av. 30 mo.	All cases, averaged 11 mo.
Smedal and Salzman	15 cases, 28.0 mo. 8 cases showed metastases at first examination	11 cases, averaged 15.7 mo. Variation, 1–92 mo.

*Portmann's Classification.

Once metastases have occurred, the life expectancy drops. Burch gives fifteen and a half months as an average for all grades, stating that the lower the grade of the primary lesion, the longer the duration of life after occurrence of metastases. Bouchard's cases show a survival of seven and four-tenths months in group I, fifteen and two-tenths months in group II, and fourteen and six-tenths months in group III. Toumey's cases showed an over-all survival of eleven months. Geschickter and Copeland and Burch stated that irradiation definitely prolongs life.

Metastases to bone from carcinoma of the breast are relatively sensitive, and doses to the tumor of from 500 to 800 r will relieve pain, according to Roberts. We generally give 1,500 r, measured in air, to a single portal, and if it can be cross-fired, 1,000 to 1,200 r to each of two ports. There are numerous testimonials to the fact that with such doses breast metastases will recalcify and pain is relieved sometimes before therapy has been completed (figs. 1 and 2). Metastases are usually evident elsewhere and the disease fatal before the treated lesions again become active.

Betoulieres in 1945 reported a patient with breast carcinomatosis who was bedridden and who received several series of teleoroentgen therapy in doses of 50 r three times weekly with ten treatments in a series. She recovered enough to be up and around for two years with supplementary series. The only untoward reaction was anemia and leukopenia, which would drop as low as 3,000,000 erythrocytes and 2,000 leukocytes, at which point he would suspend the spray treatment and allow the blood to recover. Medinger and Craver, in 1942, stated that total body irradiation had no effect on generalized carcinoma.

Dresser, in 1936, reported on a five year follow-up of 59 patients with breast carcinoma with bone

Fig. 1 (case 1).—Pelvis showing extensive destruction in right ilium from breast carcinoma.

Fig. 2 (case 1).—Regeneration in right ilium following x-ray therapy.

metastases who received irradiation castration. Of 30 patients under the age 45, 30 per cent showed regression of metastases in varying degrees, relief of pain, and general improvement in well-being which persisted for several months to two or three years. Temporary relief of pain was obtained in 43.3 per cent, but there was no regression of the bone lesions. No change occurred in 26.6 per cent. Of the 29 patients over the age of 45, none showed regression of the bone lesion by the roentgenogram, 48.2 per cent had some relief of pain which he presumed was owing to the direct effect of the irradiation of the lower spine and pelvis, and 51.7 per cent were not benefited. Today we may speculate that those in the older age group who were benefited may be related to an ovarian effect as well. The average dose Dresser gave was 600 r to each anterior and posterior pelvic portal with 15 by 15 cone, measured in air.

At the recent meeting of the American Roentgen Ray Society, Reynolds, Leucutia, Cook, and Corrigan reported promising results from a combination of colloidal lead therapy intravenously combined with deep x-ray therapy. They stated that the lead is deposited in greater quantities in active bone, that there is a lethal effect from the lead itself on carcinoma cells, and that radioactivity is induced in the lead by the x-ray irradiation in addition to the effect of x-rays *per se*. The survival rate in 350 cases averaged three years, and that is twice the usual expectancy.

The influence of estrogenic or androgenic medication on the ultimate course of this disease has as yet not been evaluated satisfactorily. With the exception of the group of English investigators[12], no large group of patients with breast malignancies has been accumulated or followed for sufficient time to draw final conclusions. English investigators studied 100 patients with carcinoma of the breast who had been treated with diethylstilbestrol. They found significant but temporary initial regression of the local lesion in a fair proportion, but the ultimate course of the disease was in no way altered. There appeared to be no prevention of lung, bone, or other metastases. Haddow and co-workers compared the effects of diethylstilbestrol, triphenylchlorethylene, and triphenylmethylethylene (the latter two being synthetic compounds having some estrogen-like activity). In 1 of 14 cases of breast carcinoma, there was prolonged improvement with diethylstilbestrol. This was an 80 year old woman in whom bony metastases developed during treatment. The usual dose was 15 to 40 mg. weekly by mouth or smaller doses intramuscularly. Trials with triphenylchlorethylene (22 patients) and triphenylmethylethylene (7 patients) showed somewhat less satisfactory response; neither agent produced prolonged improvement or reparative changes in the bony metastases. Binnie reported 1 of 4 cases in which there was healing of a sternal lesion in three weeks on diethylstilbestrol, with no recurrence at the time of reporting eight months later. Treating 17 patients with advanced carcinoma of the breast, Herrmann *et al.*, using ethinyl estradiol, noted a favorable response in 7; only 2 had bony metastases. In 1 patient who had involvement of the spine, pelvis, ribs, femora, and skull, the lesions progressed and she died two months after estrogenic therapy. The second patient with metastatic lesion to the pelvis was reported to be in good condition four months after institution of estrogenic therapy. A final verdict on the efficacy of estrogenic therapy in this disease must await the results of prolonged and more numerous trials and with larger dosages in less advanced cases than those in which treatment hitherto has been given. The mechanism of any beneficial action derived from this therapy is not clearly understood. It is believed that, in addition to depression of pituitary gonadotropic activity (Moore and Price), the synthetic estrogens may have a specific antitumorigenic effect on the malignant cells themselves[3] (figs. 3 and 4).

Fig. 3 (case 2).—Fifty-five year old man with adenocarcinoma of the breast, showing destruction of left ischium.

Fig. 4 (case 2).—Regeneration following the use of stilbestrol, 15 mg. daily.

Fig. 5 (case 3).—Destruction in right femoral neck of a woman, aged 50, with carcinoma of the breast.

Fig. 6 (case 3).—Recalcification in right femoral neck following small dose of x-rays plus testosterone.

Androgenic therapy in cases of breast carcinoma seems to hold greater promise as to its effect on both soft part and bony metastases and on the primary lesion. Adair and Herrmann, reporting on 11 cases of advanced carcinoma of the breast, obtained marked improvement in 4 patients, 3 of whom had osseous metastases. These 3 received a total of 2,150, 2,400, and 4,100 mg. of testosterone propionate over a period of about ten weeks. All 3 showed regenerative changes in the bony lesions. Only 2 showed concomitant increases in serum alkaline phosphatase, but serum calcium and phosphorus levels were normal in all 3.

Fels reported calcific healing of extensive osseous metastases in 1 of 3 patients following treatment with 1,550 mg. of testosterone over a five month period. On the other hand, Farrow and Woodard cautioned that in certain instances testosterone accelerates the bony metastases. They used smaller doses and reported increased bone destruction and hypercalcemia in 3 cases.

From the reports it appears that estrogenic therapy may actually be deleterious in the premenopausal woman and testosterone in those showing hypercalcemia. The purpose of castration and hormone therapy in genital malignant disease in both the female and the male appears to be, in the light of present knowledge, de-estrogenization in the female and de-androgenization in the male. Aschheim and Zondek first pointed out that there was an appreciable increase in pituitary gonadotropic factor excreted in the urine in cases of genital malignancy (testis, uterus, and ovaries). That estrogens are being used in cases of malignant disease of the female breast is not paradoxic if it is recalled that large doses of estrogens will depress pituitary gonadotropic activity in females as do androgens. The production of both estrogenic and androgenic factors in both male and female, and the gonadal secretions by the adrenal gland and perhaps the liver, further complicate the task of complete biochemical castration in patients with carcinoma of these organs.

At the Lahey Clinic a series of cases of breast carcinoma on a regimen of 50 to 150 mg. of testerosterone three times weekly is being followed. At this time we can report some clinical improvement; however, sufficient time has not elapsed to draw any conclusions regarding ultimate effects on osseous and soft tissue metastases.

Report of Case

A woman, aged 50, who had had a lump in the left breast for six months, was treated by radical mastectomy elsewhere in 1944. In June 1945 the scar began to harden, and by September 1945 a small lump was present. Three weeks before admission to the clinic in January 1947, a second mass appeared below the first one.

On physical examination, a mass, 8 by 10 cm., was found in the upper end of the scar in the axilla and a movable mass, 3 cm. in diameter, was present over the left chest wall. A roentgenogram of the chest showed metastases in the left upper lung field.

In February, the patient was given 1,800 r (measured in air) to the axilla, 3,100 r to the left sternal area, and 2,100 r to the area of the middle part of the scar, with regression of the masses. In May (figs. 5 and 6), a lesion in the femur was discovered, and she received 900 r (measured in air) to each anterior and posterior portal. Following this she was placed on testicular hormone, 50 mg. three times weekly. By June 1947 there was evidence of recalcification in the femur. At the last visit the femoral lesion showed continuing recalcification, but left pleural effusion had developed.

This case is presented to suggest that testosterone may increase the sensitivity of bone metastases.

Metastatic Carcinoma of the Prostate

Carcinoma of the prostate will metastasize to any bone in which there is red marrow, but Marks has shown that the pelvis and sacrum are so predominantly involved that osteoblastic and mixed metastases in the pelvis are probably the result of prostatic carcinoma and, conversely, if this type of bone lesion is found elsewhere and not in the pelvis, the origin is probably not the prostate. In 108 patients with prostatic carcinoma who were examined roentgenologically, 50 per cent showed metastases in the pelvis and in only 2 did the metastases appear elsewhere than in the pelvis at the start. An osteolytic type of lesion was found three times in the pelvis and once outside the axial skeleton. Fried stated that unless the lesion is osteolytic in type, little if any change occurs after x-ray therapy. He further noted that relief of pain results from doses of 2,000 to 3,000 r (measured in air) per field.

This group (table 1) constitutes 29 per cent of our 100 cases. As in cases of breast malignancies, the spine was the most frequent site of osseous metastases; it occurred in 25 cases, with predilection for the lumbar vertebrae in 20. The pelvis (excluding the sacrum) was involved in 19 cases, and there were no cases of involvement of the skull, sternum, humerus, scapula, clavicle, or any bones distal to the elbow and knee joints. Pathologic fractures of the lumbar and cervical vertebrae were present in 2 patients. In 21 the lesions were osteoblastic, the remaining 8 had mixed lesions, and none were lytic.

The approximate duration of the primary disease before onset of osseous metastases averaged six and six-tenths months for 6 dead and eighteen and two-tenths months for 14 living patients; in 9 cases the data are inadequate for accurate estimations (table 5). In the majority of these patients (16 patients), osseous metastasis was already evident when they first came for treatment. The 6 patients not living average thirteen months from the onset of metastases to death; in the 14 living patients at the last follow-up examination, the average duration since onset of metastases was thirty-six and one-tenth months. If we subtract 1 case in which the patient has lived one hundred and twenty-five months, this figure drops to thirty months. These figures showing survival after the onset of osseous metastases compare favorably with those of Geschickter and Copeland (eight months) and Hultberg (twelve and nine-tenths months). The latter author reviewed a total of 167 patients treated by either irradiation alone or irradiation following prostatic surgery during the period 1929 to 1940. His figures are especially interesting inasmuch as neither castration nor hormonal therapy was attempted. In a series of 183 patients, Prince and Vest found 42 (23 per cent) with bony metastases on admission. They calculated an average survival of eleven and four-tenths months after the onset of metastases.

TABLE 5.—*Prognosis in Metastases to Bone from Carcinoma of Prostate*

	Geschickter and Copeland	Hultberg	Smedal and Salzman
Duration of primary disease before metastases	2 years	----------	6 patients dead, 6.6 months 14 patients living, 18.2 months
Interval between onset of metastases and death	8 months	12.9 months	6 patients dead, av. 13.0 months 14 patients living, av. 36.1 months Subtract 1 long case, 30 months

Since the advent of the treatment of prostatic carcinoma by orchiectomy and stilbestrol begun by Huggins, we have not treated patients with metastatic carcinoma from the prostate with irradiation as a routine method.

In this series of prostatic malignancies at the New England Baptist Hospital, patients are included who were not treated by the Lahey Clinic; some of the cases date back prior to the routine use of castration and diethylstilbestrol. Of the 6 patients who survived an average of thirteen months after metastases, 3 underwent castration, to 1 of whom diethylstilbestrol was also given. Of the 6, this patient had the longest survival (thirty-one months) after metastases. Of the 14 living patients, 9 had both orchiectomy and estrogenic therapy, 3 had orchiectomy alone, 2 had no therapy at the hospital, and 1 had x-ray treatment. The 2 patients in this group who survived the longest (sixty-five and seventy-one months following onset of metastases) had both orchiectomy and estrogenic therapy and 1 had transurethral resection. The other patient who is alive one hundred and twenty-five months since the onset of disease received radium instead of resection; sixty months later osseous metastases developed, following which orchiectomy was performed. Estrogenic therapy was instituted and irradiation was given to the pelvis.

There are several reports of healing of osseous metastases following castration and estrogenic therapy or castration alone; however, the instances of this occurring under estrogenic therapy alone are considerably less. Kearns reported that "several" patients showed regression of osseous lesions under estrogenic treatment. On the other hand, Rose stated in 1944 that he has never seen a disappearance of bony metastases following administration of diethylstilbestrol alone, but that when castration has been done, he has seen them disappear, with replacement by normal bone. Nesbit *et al.*, reporting on 75 patients who were treated by castration alone and 50 by estrogen alone, found no regression in ossseous metastases in the estrogen-treated group, and 33 per cent of the castrated group showed regression. The question of dose has not been properly evaluated. They concluded, "It is evident that neither orchiectomy nor estrogenic therapy will prevent occurrence or the advance of metastases in any significant proportion of cases."

Fig. 7 (case 4).—Sixty year old man with mixed type of metastases in pelvis from the prostate.

Fig. 8 (case 4).—Progression of metastases after orchiectomy.

At the Lahey Clinic an occasional patient has had temporary disappearance of bony metastases after hormonal therapy has been started but these patients have all had castration in addition. No patient thus far has been cured with this therapy, although some are alive and well for six years. In those patients in whom the carcinoma has extended beyond the prostate and those showing metastases, an orchiectomy is done routinely, and diethylstilbestrol given postoperatively. The dosage is regulated by the clinical condition and the serum acid phosphatase determinations. From 1 to 6 mg. daily is given orally, with parenteral administration if a larger dosage is required. In addition, those patients in this group who have severe obstruction have a transurethral resection at the time of orchiectomy; otherwise only a retention catheter is used for a short time (figs. 7, 8, and 9).

Fig. 9 (case 4).—Progressive bone changes despite stilbestrol in doses of 5 mg. daily. Note loss of lytic changes.

It has been found that patients with the carcinoma simplex type fail to respond as well as those with adenocarcinoma. When the serum acid phosphatase is elevated prior to treatment, it actually drops slightly following orchiectomy, and then begins to rise again unless estrogens are given in adequate dosage. There is agreement that castration alone does not remove all the circulating androgens. Because of this fact, it appears advisable in these patients to reduce the androgens further with estrogens. When the patients are unable to take diethylstilbestrol because of nausea, they tolerate other oral estrogens, such as conjugated equine estrogens.

Some clinical groups in this section prefer to use x-ray therapy to the prostate area immediately after diagnosis and whatever surgical procedure is deemed necessary, and to the bone metastases as they develop, before resorting to orchiectomy and hormonal therapy, but agreement as to the sequence of the various methods is not universal.

It is of interest to note that J. H. Lawrence[27, 28] and associates have used radioactive strontium in cases of metastatic carcinoma of the prostate and have noted that the progress of the bone lesions was halted and pain was controlled for several months. The serum alkaline phosphatase returned to normal. The only untoward reaction was a temporary anemia. They have also reported that a selective uptake of stable strontium occurs in spongiosa and epiphyses of bone, but that it does not replace calcium in normal bone formation.

Woodard and Higinbotham have demonstrated a high serum and bony alkaline phosphatase value in osteogenic tumors; in many, inactivation of the tumor by irradiation results in lowered values of both serum and bony alkaline phosphatase. Radioactive strontium has the same effect. In 6 cases of malignant osteogenic tumor and in growing bones, there was a selective uptake of radioactive strontium, so that they believe its use is justified as an adjunct to external irradiation.

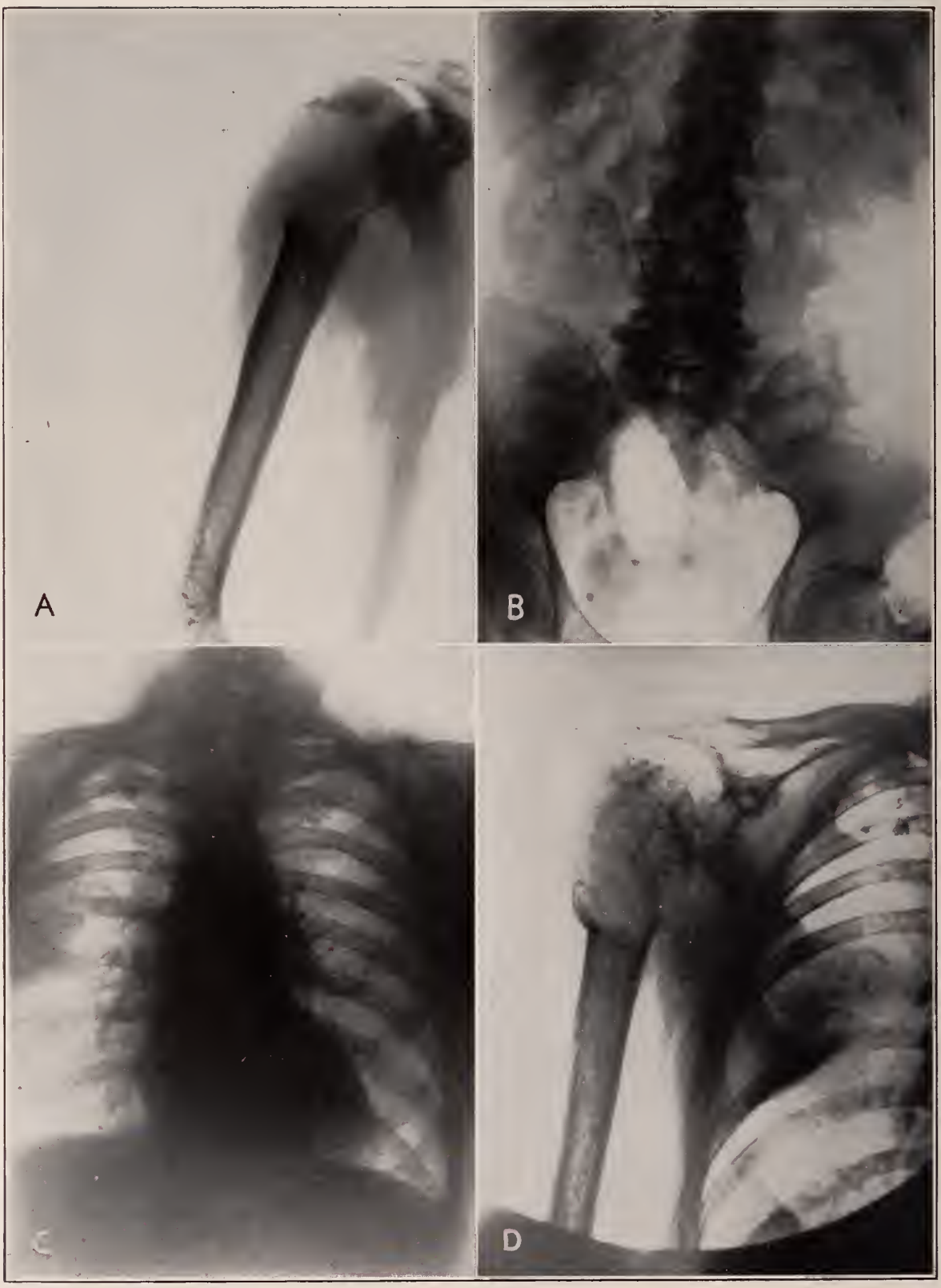

Fig. 10 (case 5).—*A*, Hypernephroma. Marked destruction of upper end of right humerus. *B*, Tumor of upper pole of left kidney. *C*, Destructive lesions of sixth and seventh right ribs. *D*, Regeneration in lesion in humerus with shrinkage of soft tissue tumor following x-ray therapy.

Renal Cell Carcinoma (Hypernephroma)

Metastases from hypernephroma are largely osteolytic in type and are widely distributed throughout the skeleton. The incidence of bone metastases as given by Geschickter and Copeland is 34.9 per cent in 62 cases, by Turner and Jaffe as 20 per cent in 25 cases of osseous metastases, and by Freid as 45 per cent in 87 cases. The distribution of lesions in 22 cases of Geschickter and Copeland were: humerus, 8; spine, 8; femur, 6; pelvis, 4; ribs, 5; foot, 2; skull, 2; and sternum and tibia, each 1. Pathologic fracture occurred in 45 per cent. These authors stated that x-rays relieve pain and prolong life although the metastatic tumor is resistant. Freid agrees that this tumor is resistant and that no healing occurs after x-ray therapy.

The site of the lesion according to Geschickter and Copeland is at the entrance of the nutrient artery. The smaller primary lesion shows a greater tendency to metastasize early. Bone metastases may occur early or late. A late manifestation is exemplified by a case one of us has seen in which metastases to the ilium occurred twelve years after nephrectomy. As evidence of early metastases, the following case is presented (fig. 10).

A man, 59 years of age, was first seen in December 1946, complaining of pain in the right shoulder with limitation of motion, of one month's duration. There was a history of being struck on the arm, with resulting hematoma, in August 1946, and in October 1946 he noted a sore arm as a result of some shooting. On physical examination, there was marked atrophy of the muscles of the arm and shoulder and tenderness over the humeral head, where a mass was palpable. Roentgenograms showed a destructive lesion in the right humerus and destruction of portions of sixth and seventh right ribs, with accompanying soft tissue masses typical of hypernephroma metastases. Intravenous pyelograms showed a tumor in the upper pole of the left kidney.

Beginning in January 1947, the patient received a total of 1,200 r (measured in air) to each of three portals to the upper right humerus. Relief of pain began after the first day's treatment. He subsequently received 900 r (measured in air) to anterior and posterior portals in February. A total of 4,500 r (measured in air) was given to the sixth rib between February and May of 1947. The soft tissue mass in connection with the rib lesion did not change, and relief of pain was not as striking as in the humerus. Roentgenograms of the humerus in June showed that definite recalcification was occurring. Motion was limited because of contractures, but it was improving slowly at his last visit.

This case illustrates the variability of response in metastases from the same primary lesion and shows that relief of pain may be expected early and that, with sufficient dosage, metastases may regress (fig. 11).

Geschickter and Copeland's statistics indicate that the survival time in cases of hypernephroma after metastases to bone have occurred is just under a year (table 6).

Fig. 11 (case 6).—Unusual type of metastasis showing marked periosteal reaction from hypernephroma.

TABLE 6. *Survival Time after Bone Metastases from Carcinoma of Kidney*

Geschickter and Copeland	Smedal and Salzman
12 patients lived an average of 11 mo.	3 patients living an average of 7 mo.
1 patient living at 76 mo.	1 patient lived 1½ mo. after onset of metastases and 7½ mo. after onset of disease

Carcinoma of the Thyroid

In this series of cases there were 2 metastatic tumors due to thyroid carcinoma. We were not able to follow them, so at this point we would like to insert 6 cases taken from a five year follow-up on 238 cases of thyroid carcinoma from the Lahey Clinic series (table 7). The average duration of the original disease before the patient sought treatment was six and three-tenths months; the interval between treatment and the appearance of bone metastases averaged thirty-three and three-tenths months. The survival period for all patients after bone metastases developed was eighteen and a half months. The over-all survival ranged from eleven to one hundred and ninety-two months, and averaged fifty-eight and one-tenth months. The high longevity is due to case 6, which was a case of papillary cystadenoma in aberrant thyroid (table 7). Three cases were carcinoma simplex, and 2 were carcinoma of

giant cell type, both of which in these 238 cases showed by far the poorest prognosis of any type.

TABLE 7.—*Prognosis with Metastases to Bone from Carcinoma of Thyroid*

Case	Duration before Operation, Mo.	Interval between Operation and Metastases, Mo.	Survival after Metastases, Mo.	Over-all Survival, Mo.
1	12	6	6	24
2	2	9—	?	11
3	8	19	6	33
4	2*	46	7	55
5	2	12	20	34
6	12	108	72	192

*No x-ray treatment
Note: 5 year follow-up on 238 cases.

The patient in case 5 survived twenty months after onset of bone metastases which involved the skull and femur. X-ray therapy to the occiput over a period of two months totaled 5,400 r and resulted in shrinking of the tumor, and by roentgenologic examination there was evidence of some recalcification in the bone. Pain was relieved after each series of 2,000 r, but the tumor did not regress from such a dose. Thus, thyroid metastases reflect the sensitivity of the original tumor, for, as noted previously, the five year survival of patients with carcinoma of the thyroid of simplex and giant cell types is less than a fourth of that seen in cases of papillary adenocarcinoma.

The use of radioactive iodine in thyroid disease is by far the most promising of the radioactive isotopes. We have had no personal experience with these substances. The reports from the New York workers[15] indicate that the selective uptake of radioactive iodine depends upon two conditions: first, the thyroid must be removed or irradiated to make it inactive; and second, the uptake in metastases is higher in those which more closely approach normal thyroid structure.

Keston, Ball, Frantz, and Palmer, in 1942, reported a case of carcinoma of the thyroid with multiple bone metastases, of which only one lesion in in the femur picked up the radioactive iodine. At autopsy the femoral metastasis was well differentiated, but the others showed undifferentiated carcinoma. Seidlin, Marinelli, and Oshry, in December 1946, reported a case in which fifteen years (1939) after total thyroidectomy metastatic thyroid carcinoma developed in the twelfth dorsal vertebra and in the following two years (1941) pulmonary, femoral, rib, pelvic, and skull metastases developed which were refractory to irradiation. In 1942 from October to May, therapeutic doses of radioactive iodine were given orally, with definite improvement. Subsequently, in April 1944 and March 1945, further therapy with radioactive iodine was given, with the result that the thyrotoxicosis from the metastases changed to hypothyroidism. Roentgenograms showed arrest of progress and some regression of the metastatic disease.

Carcinoma of the Lung

Bone metastases from carcinoma of the lung occurred in 4 cases in this series, and in all 4 metastases were present at the time of admission (table 8). Three patients were in extremis and died during the hospital stay, and 1 patient lived two and a half months without further therapy. The metastases were widespread and multiple, involving ribs, skull, spine, femora, and pelvis. Two were osteolytic and 2 osteoblastic in type. Geschickter and Copeland stated that there is slight bone formation within the area of destruction. X-ray therapy will relieve the pain of bone metastases as in other types, but does not alter the course of the disease.

TABLE 8.—*Prognosis in Metastases to Bone from Carcinoma of the Lung (4 Cases)*

Case	Duration before Treatment, Mo.	Interval between Diagnosis and Metastasis	Over-all Survival, Mo.
1	6	0	6
2	8	0	8
3	12	0	12
4	3	0	5½

Miscellaneous Groups

There were no cases of bone metastases from the cervix in this small group (table 9). Warren[40] reported 5 of 132 autopsy cases, with 3 in grade II and 2 in grade III. He stated that there is a close relationship between the grade of the tumor and the power and number of sites of metastases. Four of the 5 cases appeared in the first year. Bonte and Schaffner's figures are in agreement with those of Warren. Geschickter and Copeland found an incidence of 2.8 per cent of bone metastases and stated that some relief may be expected from x-ray therapy.

TABLE 9.—*Time of Appearance of Metastases to Bone from Carcinoma of Cervix*

Source	
Warren: 80 per cent of bone metastases occur in first year after treatment of primary lesion	
Bonte and Schaffner: In 9 cases, bone metastases occurred within 6 months after treatment of primary lesion	
In 5 cases, bone metastases occurred 1 to 6 years after treatment of primary lesion	
Occurrence as to grade:	
Grade 1	0 cases
Grade 2	2 cases
Grade 3	9 cases
Grade 4	1 case

Bone metastases from the gastrointestinal tract are thought to be unusual, but Turner and Jaffe found 11.1 per cent in 188 patients dying of carcinoma of the colon, 7.4 per cent of 107 cases of carcinoma of stomach, and 6.3 per cent of 16 cases of carcinoma of the pancreas. Of a total of 391 cases of death from carcinoma of the gastrointestinal tract, 7.9 per cent were metastatic to bone and 20.5 per cent to lung. In our mixed series, there were 3 from carcinoma of the rectum, 1 each from the esophagus, transverse colon, descending colon, and sigmoid, and 2 from the pancreas.

An interesting feature of stomach metastases is that there may be widespread replacement of bone marrow with resulting pseudopernicious anemia[23]. This may also be seen in carcinoma of the breast.

Discussion

There is a wide discrepancy in the published figures on the incidence of metastatic disease to bone, which can probably be explained on the failure to screen the skeleton properly with radiographs. For a number of years we have attempted to convince the clinician that in cases of malignant disease or suspected malignancy it would be to the advantage of the patient as well as to the family for the physician to survey the skeleton routinely. We label this a metastatic series and we include single films of the chest, thorax crosswise in a 14 by 17 mm. film to include the shoulders, pelvis and hips, lateral cervical spine, anteroposterior and lateral of the dorsal and lumbar spine, and a lateral roentgenogram of the skull. This should reveal the majority of metastases and with it one could give a better estimate as to proper treatment and prognosis, for many lesions may be single and instead of giving palliative doses for pain only, the course of the disease might be prolonged.

X-ray therapy is the best single method of palliation in most cases of metastatic bone tumors. Its effect, according to Koenig and Culver, is due first to its action on the accompanying nonspecific inflammatory process, since in many cases the relief of pain is so rapid. The second effect is on the malignant lesion itself, with resulting shrinkage in size and hence less periosteal distention and less pressure on nerve roots and nerves.

We believe treatment should be palliative and usually given only when symptoms are present. It is certainly proper to treat areas where there are no definite changes but symptoms are present and the patient is known to have carcinoma.

The amount of therapy is an individual problem. In this clinic usually we give 1,500 r (air) per portal, repeating when necessary for relief of pain. If a single lesion is present, we attempt to destroy the tumor with larger doses. We have been using 200 kv., with filtration of 1 mm. of copper and 1 mm. of aluminum at 50 cm. distance.

The hormonal approach is an interesting one. Certainly the treatment of carcinoma of the prostate has changed, and there is a distinct improvement in survival rate from some combination of x-ray treatment, orchiectomy, and stilbestrol. The patient, too, has had better palliation.

Although the use of hormonal therapy in breast metastases is still in the experimental stage, palliation in advanced cases cannot be disputed and the beneficial effect of castration in some individuals in the premenopausal group is well known.

The use of radioactive substances has been limited so far to use of radioactive iodine in cases of thyroid carcinomas with beneficial results, and a few patients with prostatic metastases and bone tumors have received radioactive strontium, with slight improvement.

Radioactive phosphorus has not been discussed here because its use has been most efficacious in cases of chronic and subacute leukemia and polycythemia.[42] According to Hoster and Doan, radioactive phosphorus is not of value in Hodgkin's disease, resulting only in a depression of the bone marrow.

We should like at this time to deprecate the use of experimental substances alone in metastatic bone disease, necessitating opiates for pain, when a relatively small dose of irradiation may entirely relieve the pain.

There are other methods of palliation, namely, by drugs. We have found that Dilaudid Hydrochloride in doses of 1/24 grain produces less nausea and constipation than morphine, and we use it before resorting to morphine. Cobra venom has not been successful in this clinic.

We must not forget that many of these bone lesions impose orthopedic problems, particularly pathologic fractures of the long bones and compression of the spine. In lesions of the long weight-bearing bones, the danger of fracture must be guarded against.

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WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION OFFERS SCHOLARSHIPS

The Wisconsin Anti-Tuberculosis Association is again offering two free scholarships to qualified Wisconsin physicians to attend postgraduate courses in New York in the fall of 1948. The first will be a four weeks' course on tuberculosis conducted by the Trudeau School of Tuberculosis at Sananac Lake, New York, September 13 to October 9. This will be followed by a two weeks' course in diseases of the chest at Bellevue Hospital, Columbia University, New York City, October 11–22. The scholarships include the full fees ($150), transportation ($100), and maintenance ($250). Scholarships are open to recent graduates of approved medical schools, and preferably to those who have had some experience in the field of tuberculosis or who plan to specialize in internal medicine.

For an application blank, write to The Wisconsin Anti-Tuberculosis Association, Medical Scholarships Committee, 1018 North Jefferson Street, Milwaukee 2, Wisconsin. Applications must be returned by August 1, 1948.

Some Thoughts on the Surgery of Retinal Detachment*

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Editor-in-chief of the American Journal of Ophthalmology, Doctor Vail holds the position of professor of ophthalmology at Northwestern University Medical School. During World War II he served as senior consultant in ophthalmology on Major General Paul R. Hawley's staff, receiving citations from the American, French, and Belgian governments for this service. He was formerly professor in ophthalmology at the University of Cincinnati Medical School.

THE surgical treatment of detached retina by the production of adhesive choroiditis by some means or other is no longer a novelty, nor is the prognosis quite so desperate. Every ophthalmologist is familiar with Gonin's basic and invaluable contribution to the elusive subject of retinal detachment and its cure. Jules Gonin did not hit upon his discovery by accident. A study of his work shows that for seventeen years prior to his epoch-making paper in 1921, he thought deeply over the problem, studied his cases over and over, wrote much, and reviewed innumerable pathologic specimens and eyes. The sceptical ophthalmic world, however, was not entirely convinced of the value of his discovery until 1929, when he presented his magnificient paper at the International Ophthalmological Congress in Amsterdam. He died in June 1935, and was awarded posthumously the von Graefe Medal, one of the most cherished prizes in ophthalmology. On the fly leaf of my copy of his book, published in 1934, he wrote "*post pessimissimum spes nova.*" He lived long enough to reap the fruits of his endeavor, and from 1929 until his death, this clinic was the Mecca of ophthalmic surgeons from all over the world.

In the subsequent years, from 1929 to 1942 or so, ophthalmic literature was filled with papers by many authors reciting their experiences and demonstrating their own results, modifications, and instrumentation. Strangely enough, there are not so many papers today. Many ideas, for example, the Guist method of the use of potassium hydroxide as a chemical agent for cauterization, have fallen into disuse. Many ophthalmic surgeons who saw relatively few patients with retinal detachment gave up the operations because of their poor results. Others in this time have developed a reputation for better than average results.

In spite of much thought and many original ideas, the laws laid down by Jules Gonin still stand. These are (1) the presence of a tear, disinsertion, or hole in every case, unless proved otherwise by an exhaustive investigation; (2) the localization of the hole or tear as accurately made as possible; (3) the sealing of the hole by some measure that will produce adhesive choroiditis; and (4) the evacuation of the subretinal fluid.

A few years ago there existed a tendency to forget or at least ignore these laws. Many surgeons contented themselves with a more or less careful study of the detached area and, whether or not a hole was found, proceeded to lay down a barrage of ignipunctures often involving one quarter or more of the eyeball in the affected area. Some surgeons still do this, and I must plead guilty of doing it too, on rare occasions, although I am convinced that this is wrong, and that it is responsible in large measure for our bad results. There is no question but that widespread and numerous punctures of the sclera with the diathermy needle result in intraocular damage, much of it unnecessary. My experience has convinced me that the fundamental principles of Gonin must be concurred with, if one expects a reasonable chance for a successful result. It has also taught me not to discontinue the search when a hole has been discovered, for many times more than one hole is to be found, and these may be large or small. The examination of the patient's eye must be made with the utmost care. It must be repeated as often as is necessary for the surgeon to become thoroughly familiar with the entire fundus, the state of the intraocular pressure, the condition of the vitreous, presence and location of retinal hemorrhages, and the presence or absence of a low grade uveitis.

The exact localization of the retinal tear can be exceedingly difficult. The method of Gonin of estimating the position of the hole by so many disk diameters from the ora serrata or, in cases of holes in the posterior pole, from the edge of the optic nerve is most valuable and probably the one most frequently used. A useful measure is to regulate if possible the circle of light of the electric ophthalmoscope so that it exactly coincides with the patient's optic disk and proceed by measuring from various landmarks encountered in the area, so that the circle of light will touch its preceding edge. The use of a perimeter as advocated by George Stine is of supportive value.

The direction of the hole is best measured by Gonin's method, I believe. Here the meridians of the eye, as of a clock, are used, as you know. Great

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

care must be taken so that the eye is not rotated, a condition which always occurs when the eyes are directed up or down. Here again anatomic landmarks of the cornea or iris are useful if present, for example, a small nevus of the iris, or a corneal scar, or limbal vessels and so on.

The confirmation of the distance and exact location of the hole or tear occurs during the operation. At this time a few diathermy punctures close together are made in the suspected area, and the result observed with the ophthalmoscope. If one has been most careful in the preliminary study and estimation of the measurements, it is not surprising that the white "doughnuts" produced by the diathermy needle should be in the desired spot. If not, they should be so close to it that correction is a simple matter. Other methods, such as transillumination with the Lancaster transilluminator in the suspected area and simultaneous observation with the ophthalmoscope, can be done. The light beam from the transilluminator will shine its brightest in the area of the hole.

The patient is admitted to the hospital and placed at complete bed rest with his head between sandbags for at least three days prior to the operation. This will accomplish two things: His system will become adjusted to the required position, and his back will be comfortable by the time set for surgery. Also it frequently happens that the detachment, or the balloon, will recede. This will allow for more accurate localization of the tear and also means that shorter needles may be employed. Should the balloon recede, I believe that it carries with it a better prognosis.

The ideal anesthesia is intravenous pentothal sodium, supplemented if necessary with a retrobulbar injection of Novocaine. I have used this anesthesia for many years in patients of all ages. It has few contraindications. The instillation of local anesthetic agents should be avoided because of the clouding of the cornea that is sure to ensue. Even Neo-Synephrine will cloud the cornea after exposure, and therefore it should not be employed the day of the operation. The pupil should be dilated as widely as possible not later than four hours before the time set for surgery. The cornea should be kept protected as much as possible during the operations. This can be done by dispensing with the speculum as soon as the field is exposed and employing the arruga or similar spatula exclusively. If the field of operation is above, the lower lid keeps the cornea covered; if below, the upper lid acts as a protection. Frequent instillations of saline solution should be performed all during the operation, for it often becomes necessary to check and recheck with the ophthalmoscope the progress of the operative results.

Meticulous attention is paid to the details and instrumentation of the operation. Long needles should never be used if short ones will accomplish the result. A current that is sufficiently strong to produce charring of the sclera, and no stronger, is employed. It is generally about 30 ma. but the apparatus should be tested on a piece of meat first, and then on the sclera, and the current regulated. If the spark is feeble the field may not be dry, or the shoulder electrode not properly placed, or perhaps wet with perspiration of the patient. Some surgeons prefer the coagulating current to the cutting one, and there are arguments on both sides. This matter should be investigated experimentally more thoroughly.

The relatively small area of the tear, and this part only, should be treated with enough ignipunctures to cover the ground, and no more. If there is not much elevation of the retina, the evacuation of the subretinal fluid may be sufficiently satisfactory through the ignipuncture openings. If not, it is necessary to evacuate the subretinal fluid, either through a trephine opening, a Graefe knife, or aspiration with a blunt needle. I am convinced that the best results occur when the eye is not soft after completion of the operation. Each hole that has been discovered should be treated in exactly the same way. The intervening area should not be touched.

I have recently had a number of patients who show a staphyloma of the sclera in the affected area. I am certain that this is a more frequent occurrence than is suspected for a small staphyloma can easily escape detection even if it is exposed. For this reason, the sclera over the tear is palpated with a strabismus hook, and if a "soft" spot is discovered, it is a staphyloma. If found, it should be excised by scleral resection, for experience has taught me the hard way that diathermy coagulation here, even if successful, is always accompanied by an alarming and prolonged postoperative reaction. Furthermore, unless the staphyloma is a small one, success with diathermy is doubtful. We need to study this matter more carefully, for our knowledge of scleral staphyloma is slight.

The more severe the postoperative reaction, the poorer is the prognosis for a successful outcome. Severe and stormy reactions to the operation occur when one works too near or into the ciliary zone. Subsequent adjacent and localized areas of iris atrophy are tell-tale signs of this error. The area of the vortex veins and their subsidiaries is also a touch-me-not zone, for occlusion of a vortex vein is sure to result in extensive reaction and damage. A low grade postoperative uveitis carries with it a poor prognosis, and, along the same order, a soft eye is not to be lightly considered. The usual treatment for uveitis must be initiated early and vigorously.

A primary intraocular hemorrhage at the time of operation may subsequently clear almost entirely. Secondary ones are grave and the outlook not good. The major retinal vessels can be avoided if one observes what he is doing by repeated ophthalmoscopic examinations during the operation.

A not infrequent postoperative observation is the detection of a choroidal detachment entirely similar in appearance to that seen after cataract or glaucoma surgery. It is likely to clear up in time

of its own accord, but, because of the accompanying hypotony, retinal folds or balloons will often persist, and the operation be a failure. It is possible that this choroidal detachment occurs when one is working too near to the ciliary zone, for it must not be forgotten that the diathermy current is probably widely disseminated throughout the interior of the eye, and is also the likely cause of central serous retinitis that is sometimes encountered.

Whether or not the patient should be allowed to be up and around before the site of the ignipunctures becomes pigmented, which is generally three weeks later, is a debatable point. It is entirely possible that we are too conservative regarding this, and good results have been obtained in old and feeble patients by allowing them up and in a chair with pinhole goggles as early as one week after the operation.

In my experience, if the retina is not back in place at the end of three weeks, the operation is likely a failure, and the continuous and prolonged wearing of pinhole goggles is an unnecessary torture. I have never seen in such a case the retina become restored to position, although I am fully aware that a number of my colleagues will disagree with me.

Bilateral spontaneous idiopathic retinal detachment is a thorny problem, both from an etiologic viewpoint and from that of surgery. Vogt in 1934 advanced the theory that this condition is the result of a congenital predisposition or hereditary degenerative disease. Others, as pointed out by de Rötth, support this premise, and from my experience I am inclined to agree too. In these cases repeated operations are frequently necessary, and the prognosis becomes worse with each subsequent detachment. One must, however, pursue surgery here until the bitter end, for occasionally an eye will be saved.

The operation of scleral resection is one that promises additional help to us in our surgery of this condition. Experience has shown that it is not too difficult an operation to perform. The results are not too good, but this may be because the operation has been saved for the desperate patient, one who has had one or more diathermy operations performed upon him. It is the operation of choice when the detachment is due to a staphyloma. Combined with diathermy in other cases, especially when there is high myopia, it may develop into an ideal operation.

McKeown has analyzed the end results of 609 patients in unselected cases operated upon at the Institute of Ophthalmology of the Presbyterian Hospital, New York, up to 1940; 66 per cent were males, 34 per cent females; the majority were between 30 and 40 years of age. A positive history of trauma was obtained in 13 per cent, twice as often in males. Myopia was present in 61.5 per cent. Detachment was cured or improved in 54.5 per cent of the cases. Of all patients operated upon within one month of onset, 66 per cent were cured; within three months in cases in which not over half of the retina was detached, 50 per cent were cured; within one or three months in which three-fourths or more of the retina was detached, 20 per cent were cured. Bulbous detachment occurred in 80 per cent of the cases, of which 65 per cent responded favorably to surgery; flat detachment occurred in 20 per cent of the cases, of which 75 per cent responded favorably. The results were better when retinal holes were found. Cystic degeneration of the retina in the macular area accounts for some of the failures of reattachment.

Summary and Conclusions

1. It is time to return to the fundamental principles or laws of Gonin in the surgical treatment of detached retina. These are (1) finding a tear, hole, or dissinsertion of the retina; (2) exact localization of the hole; (3) production of adhesive choroiditis in the area of the hole, and no place else; and (4) evacuation of the subretinal fluid.

2. The anesthesia of choice is pentothal sodium given intravenously.

3. Nothing should be used during the operation that clouds the cornea and thus prevent frequent ophthalmoscopic studies during the operation necessary to determine the extent of ignipuncture.

4. Staphyloma of the sclera, responsible for the detachment, is not infrequently encountered, if looked for. It should be excised by scleral resection.

5. One should avoid in so far as possible the ciliary region and the zones of the vortex veins.

6. A severe postoperative reaction gives a poor prognosis.

7. If the retina is not back in place and the pigmented scars of the ignipuncture not easily visible at the end of three weeks, the chances of a successful result are exceedingly poor. Prolonged use of pinhole goggles in this event is unnecessary.

8. There is an important place for the scleral resection operation in this condition.

9. Meticulous attention to the details of the preoperative study, the operative equipment and technic, and the postoperative care of the patient is of the utmost significance in the success of the operation.

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Serology and Obstetrics*

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DATA in the fields of serology and obstetrics form the basis for premises which seem to justify the following conclusions:

The bisexual mechanism of reproduction, under the laws of heredity, and the fetus-mother relationship have been the controlling factors in bringing about the present variations of cell substance structure in different individuals, and thus in bringing about the patterns of blood structure that, in our infinitessimal segment of evolutionary time, have made possible the differentiation of four blood groups.

The incompatibility of human bloods is due to the fact that the cell substances of certain human beings are toxic to the cells of certain other individuals, in which case, if the blood of the donor containing these toxic cell substances is transfused into the blood of the susceptible recipient, hemolysis, agglutination, and phagocytosis of the transfused red cells takes place, if the blood of the recipient contains inherited or acquired specific antitoxins against the toxic cell substances.

The so-called natural isoagglutinins in blood group composition and all actively generated isoagglutinins, known and unknown, are the functioning agglutinative arms of specific antitoxins, the other arms being the lytic and opsonic arms. This can be clearly demonstrated in transfusion autopsies, in which the transfused red cells are seen to have been hemolyzed, agglutinated, and phagocytized.

Thus, it is reasoned, that the patterns of the blood groups depend upon the present day inheritance of relatively strong anti-A or anti-B, or both antitoxins, by individuals whose cells are susceptible to the poisonous effects of the A and B cell substances. Thus, for example, the blood of the O group individual contains a complement of anti-A and anti-B antitoxins. It is reasoned that these antitoxins were not drawn from out the boundless deep for the purpose of killing the individual in the event of the gross transfusion of incompatible blood (gross transfusion is not a natural phenomenon), but these antitoxins have been evolved as a result of survival interests and give a modicum of protection to a woman of the O group if she happens to engender products of conception whose cells contain the A or B substances and they can gain access to her blood.

The symptoms, signs, and cellular pathology of the true toxemias of pregnancy are the manifestations of the maternal cell poisoning brought about by identifiable, relatively toxic, cell substances in the products of conception. By the same token, in cases of delayed transfusion deaths, the same type of cellular injury is sometimes glimpsed, though it is less manifest because the specific toxic cell substances involved have had a shorter time to act and the pathology is obscured by the products of gross hemolysis and agglutination. We should learn to think in terms of toxic and nontoxic bloods as well as in terms of incompatible and compatible bloods.

The cells of the products of conception may be considered as an aggregation of cells all containing the basic cell substances of their common ancestor, the fertilized ovum, just as in an aggregation of specific bacteria all the bacteria contain the cell substances of a common ancestor. When the red cells of the fetus and the cell substance antigens of its fixed and red cells can gain access to the cells of the mother, and if the cell substances are toxic to the cells of the mother, and if her blood contains inherited or acquired specific antitoxins, the invading red cells will suffer the same fate as invading toxic micro-organisms. Similarly, the manifestations of disease in the mother will tend to vary directly with the relative toxicity of the toxic cell substance or substances and indirectly with the strength of the specific antitoxin or antitoxins. The strength of the antitoxins may be demonstrated and followed by titer, but these indications of antitoxin strength must be interpreted with due consideration for the antitoxin absorptive power of the products of conception.

If the cell substances of the products of conception capable of producing clinical disease are identical with those of the mother, true toxemia of pregnancy will not ensue. That all the cell substances are never identical is supported by the facts of leukocytosis and the increase in sedimentation rate in the pregnant woman.

We are still handicapped in our differentiation of the true toxemia of pregnancy from pure cardiovascular-renal inadequacy by the facts that we have not thoroughly covered all the already known and lettered substances that may at times function as a cause of true toxemia; and, furthermore, irregular cross-matching agglutinative phenomena clearly suggest that all the cell substances to which inherited antitoxins may at times exist or may be capable of provoking the active generation of antitoxin have not yet been identified.

The most frequent cell substances involved would seem to be the A, B, and Rh substances.

Fetal injury and death may result from material antitoxin attack, and, in addition, clinical observations suggest that the fetus may be susceptible to maternal cell substance attack.

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Now let us take these separate conclusions as parts of a puzzle and put them together, and we find that it reads as follows:

The toxin-antitoxin mechanism which nature uses in the interests of evolution and is exemplified in measures of offense and defense between organisms both at same and at different levels of the phylogenetic tree, nature also uses as a means of gradually permitting a change of cell substance structure within a species. Such a mechanism obtains in the human species and leads to the loss of many babies and mothers.

That we are dealing with the same toxin-antitoxin mechanism in the complicated fetus-mother relationship when the cells of the products of conception contain a cell substance or cell substances toxic to the cells of the mother is clearly demonstrable. Under such circumstances, if her complement of protective antitoxic substances represented by the natural or acquired isoagglutinins is not strong enough to protect her cells, she begins to manifest the signs, symptoms, and cellular pathology known as the true toxemia of pregnancy. Then if her cells are vigorous enough they will begin to protect themselves and strike back by the manufacture of more of the same antitoxin, and the agglutinin titer of the specific antitoxin involved will tend to rise. If the antitoxin response is too great it may injure or kill the fetus before its separation from the mother, or it may so injure the fetal cells that even if born alive death may shortly follow, or the fetal organs may begin to show signs of inadequacy at an early age.

This conflict must have begun when the first male containing a cell substance toxic to a given woman impregnated her, and under the laws of heredity the child chanced to inherit the blood substance status of the male. To meet the survival requirements of the species, the cells of women susceptible to such a toxic substance, in the course of ages, began to inherit a complement of the antitoxic substance against the toxic cell substance involved. This would seem to be the reason why a group O woman has come to inherit the so-called natural isoagglutinins anti-A and anti-B, the group A woman the anti-B, and the group B woman the anti-A. Considering just the A and B substances, it is obvious that the AB woman would not be susceptible to the action of A or B substance. Thus, to repeat, it has been a combination of the fetus-mother relationship, the bisexual mechanism of human reproduction, the laws of heredity, and the survival requirements of the species that have accounted for the composition of the blood groups in our time.

The reason why this toxin-antitoxin argument is here pursued to so great a length is because its truth must be clearly established and widely accepted if we are to successfully stimulate men to work for the development of specific antitoxins, for ready use as in snake venom poisoning, to be used in pregnancy toxemia, either after the intrauterine death of the child or after the delivery of a live child or in postpartum eclampsia.

It is quite true that our continuous improvement in reasoned empiric treatment of preeclamptic toxemia has made the accession of eclampsia a very unusual happening, has reduced our toxemia mortality appreciably, and has tended to decrease the extent of permanent injury to the mother; however, the fact remains that even under the earliest and most meticulous application of the most approved treatment, disasters still occur that there is every logical reason for believing might be obviated if we had specific antitoxins for ready use.

The everyday use of serologic data is a great practical aid. No doubt, each of us, from the beginning of our practice, has been trying, by every lead, to find some way of anticipating or prophesying whether or not toxemia is likely to develop in a woman, especially if she gives a history of a past nephritis or presents with an obvious cardiovascular-renal abnormality. Until the time that the A, B, and Rh statuses of husband and wife were routinely taken, no way appeared that gave any definitive information as to the possible accession of toxemia. In some supposedly normal women severe toxemia developed, and some of the abnormal patients went through pregnancy without the slightest change in their original manifestations of abnormality. Why this difference?

More surprising and confusing still was the fact that some of the patients that showed a toxemia in their first pregnancy had normal pregnancies later. Some, however, had a repetition of their toxemia. Why this difference?

Now, by obtaining the A, B, and Rh statuses of husband and wife, by applying the laws of genetics, and by following maternal antitoxin titers if indicated, it will become apparent that if the result of the mating is a child with the exact cell substance status of the mother, toxemia is little likely to develop. If, on the other hand, the cells of her products of conception contain an A, B, or Rh substance which her cells do not contain, a toxemia may develop, and, if it does and it arises from this cause, her specific antitoxin titers will begin to verify the fact, if her cells are not too weak and not overwhelmed. One cannot be absolutely sure that these are the only substances involved, because, as in the days when some of us were doing our best to test the fetal blood incompatibility theory and would often find a toxemia in an O group woman with an O group child, and thus discarded the idea as false in theory and unsound in practice (because we then had not the slightest idea of the Rh substance and were barking up the wrong tree anyway in using the theory of the agglutination of fetal blood as a cause), so by focusing only on the A, B, and Rh substances we cannot be sure that other cell substances are not involved. When one speaks of an O group blood, he means blood in which the A and B substances are absent. Irregular agglutination reactions in cross matching justify the assumption that not only may the group O blood contain a substance like the Rh substance, against which nature

has not yet endowed an Rh-negative blood with an inherited antitoxin, but it may at times contain some unknown substance against which nature has endowed some other bloods with an hereditary antitoxin. Be that as it may, if one establishes the A, B, and Rh status he will find this knowledge a great help, and then, if a toxemia ensues and these substances cannot be demonstrated as involved, he can test for all other known substances. In such cases, before one attributes the toxemia to a metabolic or cardiovascular-renal origin, it suggests itself that one should see if the maternal serum on the fifth and twelfth days postpartum will agglutinate the infant's red cells, in which instance, according to our known cell substance and agglutinin setups, the cells should not agglutinate.

If one proves an A toxemia in an O, Rh-positive mother with an A, Rh-positive fetus by following maternal isoagglutin titers, he will see a reasonable explanation when later she shows no toxemia with O, Rh-positive children. Furthermore, he will find that if she becomes pregnant with another group A, Rh-positive child before her previously gained immunity has greatly diminished, she is less likely to show any signs of toxemia. This active immunization in a first pregnancy would seem to be the likely reason why toxemia is statistically less frequent in multiparas than in primiparas.

Just as in bacterial toxemia, the extent to which the signs and symptoms of toxemia will disappear will depend upon how much the functional reserve has been lowered by permanent cell injury. This can all be followed and checked by postpartum isoagglutinin titers.

All the findings give one the impression that if the cell substances of the products of conception are identical with those of the mother, no matter what her cardiovascular-renal status, the mother will suffer no more damage from the pregnancy than she would in the presence of a rapidly growing benign abdominal tumor of the same size as the pregnant uterus. We are here referring to substances capable of causing toxemia. As mentioned above, that other foreign substances exist in every pregnancy would seem likely from the fact that, as in bacterial infection, the pregnant woman shows a marked increase in sedimentation rate, a leukocytosis, and at times a fever.

The findings would also seem to suggest that whether a dead fetus can be almost completely absorbed without a sign of toxemia in the mother and another dead fetus may cause marked signs of toxemia in absorption is dependent upon whether or not the fetal cell substances are consonant with those of the mother.

This understanding of the factors involved in the causation of true toxemia makes it possible to give a more reasoned prognosis as to the possible dangers of a future pregnancy.

Levine, Katzin, and Burnham, Javert, and many others have proved, it seems, beyond the shadow of a doubt, the danger to the fetus of a strong maternal antibody or antitoxin, call it what you will. In this regard, in listening to talks and reading the literature of the subject, but especially from personal experience, it would seem that there has been much loose talk in attributing stillbirths and abortions in Rh-negative women to the Rh antitoxin. It can have only a reasonable amount of truth behind it if you can definitely prove the antitoxin, and even then, as a normal child may result later even in the presence of a demonstrable antitoxin, one can be little sure that the original abortion was brought about by the toxin-antitoxin mechanism. One can be quite sure after severe erythroblastosis has obtained. It must be remembered that there are many causes of abortion and that, as far as fetal blood is concerned, it has been shown that the red cells are five times more resistant to agglutination than adult cells, and one may reasonably assume that this increased resistance may obtain against the lytic arm of the antitoxin.

It is an opinion founded on maternal fetal cell substance status and clinical observations, both in abortions and differences in erythroblastic phenomena, that maternal cell substances may injure fetal cells, as fetal cell substances may injure maternal cells. At present, this assumption can be raised to any high degree of probability only by gross clinical statistical evidence, for which numbers are now lacking. However, in the past year a striking case has been presented which, it is believed, warrants consideration.

The patient in this case was a group A, Rh-positive woman, with a group O, Rh-positive husband. In her first pregnancy, which was normal throughout, she delivered a normal group A child.

Her second pregnancy resulted in a missed abortion at six months, in which the abortus remained in the uterus for two months before a normal extrusion and without, at any time, untoward toxic symptoms or signs on the part of the mother. The child's group was not known.

She then delivered successively, after normal pregnancies, 2 normal group A children.

Her last pregnancy, in which I first saw her, again resulted in a missed abortion at about six months, the abortus again remaining in the uterus for two months before extrusion, but with no untoward maternal toxic symptoms or signs throughout the two months. Though too macerated to permit an agglutination determination, as near as we could determine by absorption technic, the child was a group O.

This case is mentioned to direct attention to a possibility of the injurious action of maternal cell substances on fetal cells. This possibility has seemed to warrant consideration in abortions and when one sees striking differences in erythroblastotic phenomena in successive cases caused by the same antitoxin but in which different A and B status existed between mother and fetus, that, if reversed, might have caused a toxemia in the mother.

Now, let us turn to blood transfusion. Of the three major causes of mortality in obstetrics—sepsis, toxemia, and hemorrhage—we have made the least progress in reducing the toll of hemorrhage throughout the country. The reason for this is un-

questionably because, either from lack of preparation or from lack of facilities, blood tranfusion or, as a temporary measure, mixed plasma has not been widely enough used. The lessons learned, particularly in the last war, may change this inertia markedly. If plasma can be administered successfully by the medical personnel on the field of battle and proper whole blood substituted in time under complicated conditions of evacuation, surely we should be able to handle a similar problem under conditions of peace.

Trained obstetricians are thoroughly aware of the group incompatibility problem and the dangers of immunization by a present or previous pregnancies or previous blood transfusions, as regards the Rh substance and other substances. In the interests of limiting the problem of fetal injury and maternal suffering and disability from Rh immunization, this knowledge should be widely disseminated to all those called upon to use blood transfusion in females, from birth to the menopause, whatever their type of practice.

It is obvious that the primary consideration as regards blood transfusion is whether or not the donor's blood will agglutinate in the recipient. However, it is an opinion that we should consider also the toxic properties of incompatible blood, and, possibly, plasma from incompatible blood. It is a logical belief that it may be the toxic cell substances contained in mixed plasma that is causing some of the liver disturbances that we are hearing so much about. Again, if the obstetrician is called upon to advise in the transfusion of infants or even in the use of intramuscular injections of blood, he should counsel the use of compatible blood as being nontoxic. The idea that it is harmless to give a child in the early months of life blood of any group, because the isoagglutinins are then too weak to cause difficulty, may be sound from the agglutination standpoint, but it would seem to be unsound from the standpoint of the possible injurious effects of the toxic cell substances involved in incompatible blood upon the cells of the infant.

The Management of the Nephrotic Syndrome in Chronic Glomerulonephritis

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Doctor Hilker received his medical education at the University of Chicago School of Medicine and Rush Medical College, graduating from the latter in 1939. Following internship and a residency at Presbyterian Hospital, Chicago, he entered military service. In 1946 he was discharged with the rank of major and joined the department of internal medicine at the Midelfart Clinic in Eau Claire.

NEPHROSIS is one of the most interesting clinical entities; each case is an individual problem requiring a complete physiologic inventory, careful chemical and laboratory control, and meticulous dietary management[1]. Most observers agree that nephrosis is a phase or part of the course of chronic nephritis; at least, most will agree that the greatest number of nephrotic patients have chronic nephritis in a "nephrotic crisis."[2] There is almost general agreement that true nephrosis, or lipemic nephrosis, is very rare. For purposes of this paper the term "nephrosis" will mean the nephrotic syndrome in chronic glomerulonephritis.

The diagnosis of nephrosis is relatively simple. The clinical findings are classic, namely, albuminuria, hypoproteinemia, edema, usually azotemia, hypercholesteremia, and a low basal metabolic rate. The meaning of each and the part each plays in the syndrome are far from simple.

The physiologic explanation of albuminuria is a defect in the basement membrane of the glomerular capillary tuft which permits the passage through of the smallest protein molecules. Since albumin is a much smaller molecule than globulin, it passes through the membrane readily and is excreted. The hypoproteinemia may be a direct consequence of the albuminuria; after a continuous loss of albumin in the urine, there develops an albuminemia and a hypoproteinemia. With loss of the albumin molecule and retention of the globulin molecule, there naturally follows a shift of the albumin-globulin ratio.

Many observers have stated that edema occurs when the plasma protein content drops below a certain critical level; however, the formation of edema is not entirely explainable on the basis of hypoproteinemia.[2] Numerous observers have cited cases of spontaneous diuresis in which there is a marked hypoproteinemia as low as 3.0 gm. per hundred cubic centimeters.[3] Recent physiologic research has shown

that there is a renal defect in nephrosis that prevents the normal excretion of sodium; there is little sodium chloride excretion in the urine of the nephrotic patient. High concentrations of sodium, however, have been demonstrated in the tissue fluid of the nephrotic patient.[2] It is also of interest to know that practically no protein was demonstrated in this tissue fluid. Other observers have suggested the role of the endocrine glands in the formation of edema, particularly the adrenal cortical hormone, desoxycorticosterone, which is known to regulate the sodium metabolism in the body. The patient with Addisonian disease loses high quantities of sodium chloride in his urine, whereas if he is given desoxycorticosterone this loss of the sodium ion is controlled. An overdose of desoxycorticosterone produces edema. Another theory as to the formation of edema has been suggested, that the posterior pituitary gland has a role in the formation of edema with its antidiuretic hormone. Still other observers have suggested that there is an element of heart failure in the formation of edema, particularly in acute nephritis, and this cardiac insufficiency persists in the nephrotic syndrome. Some cases of edema are not explainable either on the basis of hypoproteinemia, sodium retention, endocrine factor, adrenal cortex, posterior pituitary, or cardiac disease. There still is an x factor. In the report of the case to follow it will be shown how sodium retention was the main factor in the formation of edema.

The physiologic explanation of hypercholesteremia is unsolved; just what part it plays in the nephrotic syndrome has not been proved. Nor is it known why the basal metabolic rate is low and frequently in a myxedematous range. Some observers have given large quantities of thyroid to the nephrotic patient without in any way altering the syndrome. In most cases of nephrosis due to chronic nephritis there exists a potential azotemia or even a profound elevation of the nonprotein nitrogenous substances.

The production of the azotemia is the result of protein metabolism with retention of the nitrogenous metabolites.[5] There is an inability of the kidneys to eliminate these low threshold substances, which results in the elevation of the nonprotein nitrogen, urea, creatinine, and uric acid in the blood. There is good evidence to believe that the protein metabolism itself is impaired, that the nephrotic patient is unable to properly metabolize, elaborate, and utilize the protein; this will be demonstrated in the report of the case to follow by showing that high quantities of protein were ineffective in raising the blood protein level.

An analysis of the symptomatology of the nephrotic patient clearly demonstrates the difficulties in treatment. There are different conditions in the same disease requiring diametrically opposite therapies as hypoproteinemia and azotemia. The treatment of hypoproteinemia is a high protein diet, administration of plasmas, serum albumin, protein hydrolysates, etc., whereas the treatment of the azotemia is directly opposite, very low protein diet and the forcing of fluids. The forcing of fluids seems physiologically unsound in an already edematous patient. If acidemia is present, the condition is even more confusing. The purpose of this paper is to suggest a single therapeutic measure which will answer the needs of the whole problem without being in conflict with any part of the syndrome and that will stand up under a physiologic analysis. The following is a report of a case of a nephrotic patient whose clinical course bears out the contentions of this paper.

Report of a Case

The patient is a tall, white male, age 43, a station attendant by occupation. He was admitted to the hospital on December 4, 1946, complaining of swollen ankles, legs, scrotum, pelvis, and abdomen; loss of appetite; weakness; and olyguria. Approximately three weeks prior to admission "the flu" had developed, with chills, fever, and sweating; he was bedridden for seven days, up for nine more days, but was not working. On November 30 he returned to work but noticed a "bulkiness" around his abdomen which made it difficult for him to stoop over; on December 3 he noticed that his shoes felt too small, and upon removing them his ankles were swollen. He became anorexic and vomited once, and because of the increase in symptoms he was admitted to the hospital on December 4.

His past history was of some significance: He had scarlet fever in 1936, and since that time had complained of increased fatigability. He had noticed no urinary trouble except that his urine had been deep amber in color for years. He had had repeated headaches in the past years and in the last year dizziness had developed, particularly with change of position. There was no known history of kidney trouble.

On admission, his temperature was 98.8 F., respiration 18, and pulse 84. His weight was 208 pounds. Blood pressure was 150/90. Further physical examination revealed bilateral pitting edema of the ankles and legs with marked edema of the scrotum and penis; marked pitting edema of the lower lumbar region and sacrum with some degree of ascites. The patient was breathing easily. The heart was normal in size, rate, rhythm, and tones; no murmurs were heard. The urine was cloudy, with a specific gravity of 1.014 and 4 plus albumin; tests for sugar were negative; it contained many casts, few red blood cells, and many white blood cells. His nonprotein nitrogen was 54.5. Blood cell count showed hemoglobin 12.8 mg. per hundred cubic centimeters, red blood cells 4,030,000 and white blood cells 12,250; there was a normal differential picture. The total protein content was 2.75. His daily urine continued to show 4 plus albumin and some fixation of the specific gravity, ranging from 1.010 to 1.016; occasionally a urine specimen would show numerous red blood cells.

The patient was in the hospital five and one-half months, from December 1946 to the middle of May 1947. Therapy was first directed toward the hypoproteinemia (2.75) and consisted of a high protein diet, supplementary protein hydrolysates, both intravenously and orally, and restricted salt. On this program for one month the total plasma proteins were raised only 0.6 gm. per hundred cubic centimeters and the nonprotein nitrogen rose from 55 to 95. This demonstrated the inability of the body to handle proteins even in the presence of a hypopro-

teinemia. Rather than obtaining the desired effect of elevating the serum proteins in the patient in this case, high proteins served only to increase the azotemia.

Administration of the intravenous and oral protein hydrolysâtes was discontinued, fluids were forced to what had been found to be this patient's maximum excretory ability of his kidneys—1,800 cc. —and the high protein diet and salt restrictions were maintained. In another month's time on this program the nonprotein nitrogen dropped from 95 to 52 mg. per hundred cubic centimeters. Although the azotemia was reduced, clinically the patient was worse, being more edematous and generally more uncomfortable. All during this second month of treatment the total plasma protein had risen only 0.9 gm. per hundred cubic centimeters. In other words, in the combined two months of intensive protein treatment, the total plasma proteins were raised only 1.5 gm.

Because of the increased edema a program of restricted fluids was started, and the high protein, low salt diet was continued. In two weeks the nonprotein nitrogen went up ten points and the edema remained unchanged. It was obvious now that the therapeutic attack was wrong. Up to this point therapy had been directed mainly toward the hypoproteinemia. In two months' time little had been accomplished in spite of high protein intake; in fact, much had been made worse.

A new therapeutic regimen was initiated. Actual calculation of the diet revealed that the patient had been getting 2 to 3 gm. of sodium per day on the high protein, salt-restricted diet. This was not low enough, and it was reduced to 0.5 gm. of sodium per day. Since there was also a demonstrable inability of the body to handle proteins, a diet containing 0.5 gm. sodium per day and very low protein content was started. The rice diet described by Kempner[6] was inaugurated, consisting of 200 to 300 gm. of cooked dry rice with 750 gm. of fruit juices and sugar as desired; all medications containing any part of sodium were eliminated.

On this low sodium, low protein diet, the following spectacular results occurred. For the first time in the four months' hospitalization, the patient's urinary output exceeded his fluid intake by 200 cc. daily. The average intake was 750 cc.; average output was 950 cc. daily. Simultaneously there occurred a great but steady loss of weight; with the beginning of the rice diet the patient weighed 208 pounds; four weeks later he weighed 174 pounds, a loss of 34 pounds, most of which was edema.

The edema was unaltered by a restricted salt diet, but changed markedly on this quantitative diet of less than 0.5 gm. sodium per day in spite of a severe hypoproteinemia, 3.5 gm. Although the protein content of this rice diet was very low, there was no appreciable diminution of the already low serum proteins. With the beginning of the rice diet the total proteins were 3.5 gm. per hundred cubic centimeters and after one month of the diet, 3.4 gm. In addition to the spectacular loss of edema, the rice diet accomplished other interesting results. In the low protein intake, the previously retained nitrogenous products were gradually eliminated, so that in the course of one month the nonprotein nitrogen was reduced from 58 to 31 mg. per hundred cubic centimeters.

The results were threefold: 1. The patient became nonedematous. 2. For the first time he was psychologically relieved and pleased. 3. The nonprotein nitrogen was brought to a normal level. The patient was still spilling large quantities of albumin daily, up to 9 gm. a day in his urine. Seven ampules of serum albumin were available, each containing 5 gm. of albumin. One of these was given daily for seven days; although this quantity was inadequate, rather than spilling 9 gm. of albumin daily, the quantitative albuminuria rose to between 13 and 14 gm.

It was obvious that the patient could not continue on this very low protein diet, because of the hypoproteinemia and the albuminuria; extreme nitrogen deficiency would soon develop. The patient was then given 1 gm. of protein per kilogram of body weight, or approximately 70 gm. of protein daily in a fairly well balanced diet but one containing less than 1 gm. of sodium per day. On this diet he continued to be free of edema; apparently he satisfactorily utilized 1 gm. sodium per day. His nonprotein nitrogen, however, rose from 35 to 55 in two weeks' time (demonstrating once again the inability of the body to properly metabolize, elaborate, and utilize proteins).

Since the nonprotein nitrogen rose on a diet containing 1 gm. of protein per kilogram of body weight, it was decided to give him 0.5 gm. of protein per kilogram of body weight, or approximately 30 to 35 gm. of protein per day and still keep the diet less than 1 gm. of sodium per day. In one week's time on this program his nonprotein nitrogen dropped from 56 to 40. His weight went as low as 168 pounds; he was completely edema free. He was discharged from the hospital at this point and instructed to stay on a diet containing 0.5 gm. protein per kilogram of body weight, less than 1 gm. of sodium per day, with a maintenance diet of 25 to 30 calories per kilogram of body weight, rice being used rather heavily to make up the caloric content. The patient has been observed for several months following the hospitalization and remains free of edema, his nonprotein nitrogen fluctuating between 35 and 48 mg. and his weight remaining constant at 170 pounds. He still has a 4 plus albuminuria; blood pressure remains at 150/90. In the last week of examination, the patient's ability to concentrate urine has improved so that he can concentrate up to 1.020 specific gravity. Phenolsulfonphthalein test showed 40 per cent excretion in one hour.

The future of this case is, of course, still unpredictable, but it is believed that the rice diet markedly altered the course of the individual and changed his condition from becoming progressively worse to one of being decidedly better.

Discussion

This case demonstrated repeatedly the inability of the body to metabolize, utilize, and elaborate proteins. High protein intake throughout the whole course of the early treatment did little to increase the total plasma protein but did much to threaten the patient with azotemia. The azotemia was made doubly profound with the use of intravenous and oral protein hydrolysates, and their discontinuance brought the nonprotein nitrogen back to its previous level. It was increased again with a high protein diet and fluid restriction. The edema was unaltered on a restricted salt diet but was changed markedly on a quantitative diet of less than 0.5 gm. of sodium per day in spite of a severe hypoproteinemia.

If the azotemia in a nephrotic patient is due to retention of protein metabolites and the edema is due to sodium retention, it follows by physiologic

reasoning that a very low protein and quantitatively restricted sodium diet is the correct dietary management. On such a diet the protein nitrogenous metabolites that have been retained by the body are slowly eliminated until the nonprotein nitrogen becomes normal. Simultaneously, the sodium retention in the tissue will be slowly reduced until such a time as the tissue osmotic pressure is less than the capillary pressure and diuresis will take place, producing a great change in the clinical course of the patient, with a great loss of weight and reduction of edema and conspicuous improvement in the patient's psyche.

One may hope, therefore, to accomplish three things: (1) a patient free of edema; (2) a psychologically happier patient; and (3) a normal nonprotein nitrogen content. The initial diet to reduce the azotemia and to promote the diuresis is best supplied by the rice diet of Kempner. After the nonprotein nitrogen content has become normal and the patient has become free of edema on the rice diet, then trial quantities of protein in the diet should be started, such as 0.5 gm. of protein per kilogram of body weight. The sodium concentration in the diet should be less than 1 gm. per day. Fluids should be kept up to the maximum excretory ability of the kidneys. The proteins are increased or decreased according to their effect on the nonprotein nitrogen. In this manner the hypoproteinemia may perhaps be gradually built up to a normal value.

Summary

1. The cause of edema in a nephrotic patient is not primarily due to the hypoproteinemia; rather, it is the result of sodium retention.

2. A diuresis may occur in a nephrotic patient, even in the presence of a severe hypoproteinemia.

3. A diet containing 0.5 gm. of sodium per day produced an edema-free patient with serum proteins of less than 3 gm. per hundred cubic centimeters.

4. If edema, hypoproteinemia, and azotemia are present, therapy should be directed toward the edema and the azotemia.

5. High protein intake may not alter the hypoproteinemia but actually may have a deleterious effect, producing profound azotemia.

6. A patient with chronic nephritis in a nephrotic syndrome having hypoproteinemia and azotemia seems unable to metabolize, elaborate, and utilize protein.

7. Intravenous and oral protein hydrolysates are contraindicated, since they rapidly increase the azotemia and do not affect the hypoproteinemia.

8. The treatment of hypoproteinemia and azotemia are diametrically opposed to each other, and when present together as in the nephrotic patient, the therapy should be directed only for the azotemia.

9. Correction of the azotemia and edema may be accomplished by a simple therapeutic measure, namely, a very low-protein low-sodium diet.

10. The best initial diet is the "rice diet" described by Kempner.

11. The effect may be threefold: (*a*) The sodium retention is steadily reduced which may produce a diuresis in spite of hypoproteinemia with a resulting loss of edema; (*b*) The retained nitrogenous substances may gradually be eliminated, resulting in a normal nonprotein nitrogen, urea, and creatinine; (*c*) The combination of the above produces a great psychologic improvement.

12. After this has been accomplished, therapy is directed toward the improvement of the hypoproteinemia by slowly increasing the protein content of the diet and regulating it according to the nonprotein nitrogen content.

13. If the treatment is carried out as outlined, one might expect the kidneys to be in an optimum physiologic condition with minimal stress and strain and to remain within the capacity of their physiologic state. If recovery is possible and the pathologic condition reversible, the optimum condition should be present for restoration toward that normal physiologic function. If the process is irreversible and the pathologic damage progressive, the final course cannot be altered.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Chloromycetin

An Antibiotic Effective in the Treatment of Rickettsial Diseases

Rocky Mountain spotted fever, typhus, and tsutsugamushi fever (scrub typhus) are diseases caused by rickettsia for which up until recently no effective means of treatment has been known. Immunity against typhus and Rocky Mountain spotted fever can be induced by vaccination procedures but this would not be applicable to therapy.

During the war period it was found that para-aminobenzoic acid given in large dosages significantly reduced the mortality rate of patients with typhus fever providing this drug was given within the first four days. The drug apparently counteracted some systemic effect of the rickettsial organisms which were finally eliminated during the course of development of immune processes.

Very recently (1947), a new antibiotic, chloromycetin, obtained from the cultivation of a strain of the fungus Streptomyces, was found to be very effective in destroying various types of rickettsia grown in chick embryos. This antirickettsial antibiotic was found to be quite effective in the treatment of mice infected by a number of types of rickettsia and also by viruses of the psittacosis group of pathogens.

Chemically, the substance has as yet not been characterized, although it can be obtained in crystalline form. It is soluble to about 2.5 per cent in water, freely soluble in alcohol, fairly soluble in ether, but insoluble in benzene, does not reduce copper of Benedict's solution, and apparently does not contain a phenol group, as indicated by absence of reaction with ferric chloride. It is stable in water, since no change in potency could be detected in solutions kept at 37 C. for a month or at 100 C. for five hours.

After purification of the new antibiotic, it was found to be relatively nontoxic to laboratory animals and to man, which then justified its trials in human rickettsial diseases, such as typhus fever, Rocky Mountain spotted fever, and the oriental tsutsugamushi fever. In May 1948, Smadel and associates presented a preliminary summary of their study of scrub typhus in Malaya before the Fourth International Congresses on Tropical Medicine. A series of 25 patients were treated, with dramatic results. The ages of the patients varied from 19 to 55 years, and the duration of the disease prior to treatment was from three to eleven days. Fever lasted from ten to ninety-six hours, with an average of thirty-one hours in the whole group. There were no deaths. Twelve patients infected in the same areas as those treated were permitted to serve as untreated controls. The mean duration of fever in this control group was eighteen days. One patient died of complications. Each of the treated patients was given an initial dose of 40 mg. per kilogram of chloromycetin orally and 0.2 to 0.3 Gm. every two to four hours for varying periods of time. Later in the study, treatment was completed in a period of twenty-four hours, with the administration of a total of approximately 6 Gm. These patients appeared to respond fully as well as those who were treated throughout a period of several days.

The fact that at the present time there is no rickettsial disease in Wisconsin is no assurance that this state will remain free, since the existence of rickettsia of Rocky Mountain spotted fever is all too common as far East as the state of Maryland and beyond. The discovery of this new antibiotic constitutes a most welcome addition to the therapeutic armamentarium of the medical profession in all those regions in which rickettsial diseases are, or may be, endemic.

It should be recalled that the wood tick, the common insect vector of Rocky Mountain spotted fever, passes the rickettsia from generation to generation of ticks via the eggs. Hence this type of rickettsial organism does not appear to need directly any other host than the tick itself. The welfare of the host tick apparently supplies complete requirements for the rickettsial organisms, which fact illustrates the difficulties in eradication of this disease.—A. L. TATUM, M. D.

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Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

SEROLOGIC TESTS FOR SYPHILIS

(Continued from last month)

False positive reactions occur fairly regularly in leprosy. They also occur in any disease which is caused by spirochetes, either identical with or similar to the Treponema pallidum. Such diseases as yaws and pinta are unknown in Wisconsin and need not be considered. False positives do occur in a number of fairly common diseases such as malaria or infectious mononucleosis and in persons who have been recently vaccinated for smallpox. There are also a few individuals whose blood always gives a positive result with any of the standard tests. No cause for this phenomenon can usually be found in such individuals. At the present time there is no laboratory test whereby such false positive reactions can be separated from positive reactions which are due to syphilis. The test with Pangborn's antigen is reputedly more specific than any of the present day serologic tests. This, however, still has to be proved in routine practice. The biologic verification test of Kahn has failed to give uniformly consistent results, and it must be labeled as simply another test which may or may not be of value in the individual case. The reagin titer of the blood is often determined under the mistaken notion that high titers are indicative of syphilitic infection while low titers are not. Such a conclusion is erroneous, as very high titers are often found in some of the false positive reactions, and a true syphilitic titer may be relatively low.

When the physician is called upon to handle cases in which a false positive is suspected, he should always proceed slowly. In the absence of physical findings and when the individual emphatically denies exposure to syphilis, it is well for the physician to postpone treatment, at the same time keeping the patient under close observation. In many cases the false Wassermann reaction will become negative over the course of a few weeks or months. The first and most important thing the physician should do in such cases is to have the serologic test performed in another laboratory. Since all of these tests are prone to considerable variation, one often finds that tests which are positive in one laboratory will be negative when they are handled by someone else in another laboratory. A battery of tests may also be done on the theory that the false positives are more apt to show considerable fluctuations in the degree of positivity than a true positive. This is not invariably true but has proved to be true very often. Treatment should not be started until one has assured oneself that syphilis is actually present.

The persistence of a positive Wassermann reaction is not necessarily an indication of the persistence of the infectious form of syphilis, any more than the persistence of typhoid antibodies in the circulating blood following infection means that the individual is still suffering from clinical typhoid fever. Many individuals, particularly those whose treatment is started late, never become serologically negative even though they receive extensive treatment. Once such persons have received an adequate course of therapy, they should be kept under observation but not treated unless there is clinical evidence of progression of the disease. This problem is becoming more and more important as pre-employment physical examinations increase in number. It is also a complication which sometimes arises when such individuals apply for a marriage license. There are adequate regulations covering the handling of persons in the latter category. In industrial practice there is no standard procedure. It would probably be beneficial to all concerned if all syphilitic individuals were given a standard record showing the dates and amount of treatment which has been given. This would serve as a handy record of his case which could be presented to a prospective employer and save considerable nervous energy when a routine serology report comes back as positive.

—EDWARD A. BIRGE, M. D.

Attention is called to "An Open Letter to the Physicians of Wisconsin" by Dr. J. F. Kuzma, president of the Wisconsin Society of Pathologists, which is included in the "Correspondence" on page 720 of this issue.

The
MEDICAL FORUM

The Wisconsin Medical Journal — July, 1948

GUNDERSON ELECTED TO AMA BOARD OF TRUSTEES

AMENDMENT REMOVES DOCTORS FROM DRAFT

Washington, D. C., June 21.—In the final hours of debate on the recently enacted draft bill an amendment was introduced and passed removing physicians, dentists and other professionals from the special classification that would have made them subject to induction.

Author of the amendment was Rep. William J. Miller (R., Conn.), who lost both legs in an airplane crash as a military aviator in World War I. During the debate he told his congressional colleagues that "I am sure we do not want to pass any section of this bill that will cast any reflection on the patriotism of the medical profession or write any language in the bill that the medical profession feels does cast a reflection on their patriotism."

Many "doctor–lawmakers" participated in the debate preceding passage of the amendment. Rep. Ivor D. Fenton, M. D., (R., Pa.), praised AMA leadership in World War II in helping supply 60,000 medical officers for the military and voiced resentment of any effort to single out doctors for induction. Rep. Walter E. Brehm (R., Ohio), a dentist, charged that the Navy would not accept 2,700 dentists "who are pleading to enlist" because to do so would have filled the shortage and made drafting unnecessary.

ON THE INSIDE

Subject	Page
AMCP–Blue Cross	3
Basic Science Laws	4
Cash Sickness	2
Capitol Views	6
Chiropractors	6
Crippled Children	6
Infirmaries for Aged	5
Nations Health	5
Prepayment Plans	2
Public Relations	6
Socialized Medicine	3
Wisconsin Physicans Service	2
WVMSA	7–8

Gunnar Gundersen

SEEK UNIFORMITY IN VA PROGRAMS

Blue Shield Plans Want Uniform Contracts for VA Medical Care

Chicago, June 1.—Eleven Blue Shield plans, in their capacity as intermediary contractors with the Veterans' Administration, are completing final efforts to achieve uniform contracts and administrative procedures for their "home-town" veterans medical care programs.

In some states the veterans medical care program is operated as a part of the physicians service plans (Blue Shield Plans) of prepayment insurance. Wisconsin has a separate agency for this purpose.

With assurance of cooperation from the VA office in Washington, D. C., proposals for uniform administrative procedures and contract changes were distributed recently by the national Blue Shield office to the 11 plans directly involved.

A special Blue Shield committee on veterans care met in Denver on June 17 to study the proposals before submitting its final recommendations to the VA headquarters office.

Speaker of House to Serve Five-Year Term

Chicago, June 24.—Dr. Gunnar Gundersen, La Crosse, was elected a member of the Board of Trustees of the American Medical Association at a meeting of the House of Delegates at the annual convention. He will serve a five year term.

Dr. Gundersen is speaker of the House of Delegates of the Wisconsin State Medical Society, president of the State Board of Health, past president of the State Medical Society, former regent of the University of Wisconsin and a preceptor of the Wisconsin Medical School.

At the same session, AMA delegates named Dr. Ernest E. Irons, Chicago, to be president next year. Other officers elected included: Dr. Roy W. Fouts, Omaha, Neb., vice-president; Dr. Francis F. Borzell, Philadelphia, speaker of the house of delegates; Dr. Edward S. Hamilton, Kankakee, Ill., and Dr. Walter B. Martin, Norfolk, Va., trustees.

More than 200 Wisconsin physicians attended the business and scientific sessions of the convention. Twenty-three state doctors presented scientific papers or exhibits at the meetings.

Exhibitors from the state included Dr. Sture A. Johnson, University of Wisconsin, skin diseases; Dr. Frederic E. Mohs, University of Wisconsin Medical School, chemosurgical treatment of cancer of the skin; Dr. Arnold S. Jackson, Madison, diagnosis and treatment of hyperthyroidism with iodine, propylthiourcil and surgery, and a demonstration of how a county medical society attacks cancer by Drs. J. C. Griffith, L. J. Van Hecke, C. Sherrill Riff, R. A. Frisch, James G. Garland, J. J. Gramling, Jr., James M. Sullivan, and Mr. J. O. Kelley, of the Medical Society of Milwaukee County.

(Continued on page 2)

Workers Under Cash Sickness Benefit System Can Increase Weekly Earnings By Being Sick

Rhode Island Experiment Is Solvent But Expensive

Chicago, June 10.—The Rhode Island system of cash sickness benefits, which has just completed its fifth year of operation, is a "costly luxury and a dangerous political football," declared Elizabeth W. Wilson in the *Christian Science Monitor* of May 15, 1948.

Since April 1, 1943 more than 300,000 Rhode Island workers have been entitled to cash benefits ranging from $6.75 to $18 a week whenever they were sick. They get nothing for the first week, but after that they are paid for periods varying from about four to twenty weeks depending on their weekly benefit rate and wage credits. Workers who make $1,800 or more may receive the maximum—$18 for 20¼ weeks, she said.

"Costly Luxury"

Miss Wilson reports that the system is a "costly luxury." She explained that "had Rhode Island workers paid an actuarial premium, almost three fourths of them would have paid the present system more than they would have given private carriers for equally favorable coverage."

Many workers under the system made more for themselves when they were sick than when they worked, she added. "For instance, a woman worker at one of the big plants made $30 in wages; that is, she took home about $27 a week. She strained her back while working. Her weekly benefits amounted to $47, tax free and deduction exempt."

Actuarily Unsound

The worker's contribution to the fund is 1½% of his wages. The plan made a $1,000,000 surplus the first year, but since then the utilization has become so great that special investigations were made, Miss Wilson wrote. Legislation made the benefits less liberal, but $28,000,000 made available by congressional action on the employment compensation laws increased the state's reserves. Since then, Miss Wilson wrote, a liberalized policy of benefits, elimination of employee contributions and raising of the administrative expense have made the plan actuarily unsound.

WPS Pays Quarter Million in Benefits in 13 Months

Madison, July 8.—Medical and surgical benefits totalling nearly a quarter of a million dollars have been paid for patients by Wisconsin Physicians Service (WPS), according to Dr. C. O. Vingom, Madison, chairman of the plan's directing board. WPS is the doctor-sponsored and directed non-profit prepayment health care plan of the State Medical Society of Wisconsin.

Preliminary reports show that coverage under Wisconsin Physicians Service was nearly 70,000 persons on July 1, Dr. Vingom stated. Medical and surgical bills paid for patients covered under the plan have totaled $250,000 in the 13 months since sale of the plan began. Nearly 2,000 doctors are actively participating in the plan.

Dr. Vingom reported the plan's total assets on May 31 to be approximately $145,000 with reserves of $37,000, and obligations of $92,000 including a liability for unearned premiums.

Blue Cross, which is enrolling and billing agent for WPS, recently conducted hospital "weeks" in Dane, La Crosse, Barron, Rusk and other counties with the support of physicians in those areas. Dr. Vingom reported. The drives brought a substantial increase in rural and industrial coverage. Dr. Vingom added that some 40 groups have been signed in Barron and Rusk counties alone.

GUNDERSEN—

(Continued from page 1)

Doctors presenting papers included: Dr. Stephan Epstein, Marshfield, dermatitis of the hands; Dr. G. L. Bellis, Winnebago, total lung rest for pulmonary tuberculosis; and seven Milwaukee doctors; W. E. Grove, ear, nose and throat; M. G. Peterman, epilepsy in childhood; M. J. Reuter, dermatitis of the hands; O. A. Sander, preventive and industrial medicine; E. L. Belknap, lead poisoning; J. C. Sargent, cancer of the prostate, and W. P. Blount, orthopedic surgery.

News of Prepayment Medical Care Plans

Management must bargain with unions on group insurance requests as well as on pension plans, the National Labor Relations Board has ruled. The NLRB recently ordered a company to cease refusing to bargain on its own group insurance program. This has a dual effect: it requires management not only to bargain with unions on group insurance requests, but also on company-sponsored programs set up in the past and currently operating without union participation.

* * *

The insurance commissioner of Massachusetts has recommended that the insurance department be given the same powers over Blue Cross it has over insurance companies. The commissioner asked authority for approval of new and higher hospital rates by the state commissioner of public health, free access to Blue Cross records and rules and regulations for enforcement of insurance department orders, and medical examinations for those holding private contracts with Blue Cross.

* * *

Blue Shield plans have recorded a total income of $48,445,000 during 1947. Payments to physicians totalled $37,942,000 or 78.14% of income. More than $7,460,000 or 15.3% of income went for operating expenses. The balance of $3,154,000 was added to reserves.

* * *

Two Blue Shield Plans—Medical–Surgical Plan of New Jersey and California Physicians Service—have been authorized by their House of Delegates to increase the income ceilings under which full service benefits are provided for subscribers. New Jersey set its ceiling at $5,000 for all subscribers, regardless of marital status, but also increased the fee schedule and subscription rates. California raised its ceilings to $3,000 for single persons and $4,000 for families and made no other changes.

High School Student Writes About Compulsory Medicine

Describes Plan as Costly, Restrictive and Inefficient

Milwaukee, June 1.—It is not possible for us to think of a national health insurance program until health facilities are more uniformly distributed, the results of planning and trial work on the community scale are known and better accord is reached on what such a project would cost the nation, declares Mr. J. C. Rogers, Milwaukee in a term paper entitled "Compulsory vs. Voluntary Health Insurance" prepared for his high school social studies course.

In his survey of the compulsory health insurance question, Mr. Rogers points out that "the Labor Government of Clement Atlee is moving the people toward an appointed day when they will no longer be able to select their own practitioners."

"For those who enroll there are two possibilities: more training or immediate assignment to some part of the Empire where the doctor must serve as many patients as are assigned to his panel."

Mr. Rogers points out that "currently, private insurance, the Blue Cross . . . and government on Federal, State and community levels reach 93½% of the total population of 133,066,045. To reach the 9½ million people who are not now provided for in some fashion, those in favor of the Wagner–Murray–Dingell bill are willing to spend, at lowest estimate, 8 billion dollars."

Group health insurance provided under the incentive plans of insurance companies does away with the danger in the Wagner–Murray Dingell bill that those who "exercise on-the-job caution, or who enjoy good health, are penalized by paying for the careless, incompetent or chronic malingerers," he said.

He called attention to the abuses of diagnosis and treatment that might arise from a compulsory system as well as the numerous restrictions that would make "care of any sort less efficient." He added that "our present financial situation does not permit unrewarding experimentation" with untried schemes.

AMA TO STUDY NATIONAL ENROLLMENT ORGANIZATION OF AMCP–BLUE CROSS

Council on Medical Service to Pass on Agency's Function

Chicago, June 25.—The Council on Medical Service of the AMA will pass on the structure and functions of a proposed national enrollment organization of Associated Medical Care Plans and Blue Cross as the result of House of Delegates approval of principles ennunciated at a meeting of the Council with representatives of 36 state medical societies on June 19.

Dr. Stephen E. Gavin, Fond du Lac, was a member of the reference committee on Medical Service and Prepayment Insurance which studied this proposal at the AMA convention. Dr. C. O. Vingom, Madison, chairman of the directing board of Wisconsin Physicians Service (WPS); Dr. W. D. Stovall, president of the State Medical Society; Mr. R. F. Weber, director of WPS; and Mr. C. H. Crownhart, secretary of the State Medical Society, attended the meeting on June 19.

At the meeting, Dr. Paul R. Hawley, chief executive officer of the Blue Cross–Blue Shield Commissions, and Dr. L. Howard Shriver, of Associated Medical Care Plans, proposed a new corporation or national service agency to supplement the enrollment activities of medical and hospital care plans, assist in extending plans to those states not fully covered, provide medical and hospital protection not provided in existing plans, sell policies in areas not served by a plan, and to aid in the enrollment of national accounts.

Those attending the meeting agreed that a national enrolling organization was needed, but differed on what should be its structure and proper functions. Upon a motion by Dr. Stovall the group agreed that the Council on Medical Service and the commission of AMCP study the structural organization and proper function of such an agency.

NO CHANCE FOR SOCIAL MEDICINE IN 80th CONGRESS

Expect Renewed Fight in Next Session

Washington, June 1.—Socialized medicine has been killed as far as the 80th congress is concerned, but will probably be in for considerable attention when the new session convenes next year, Sen. H. Alexander Smith (R., N. J.) reported.

In a senate speech, Sen. Smith said all bills relating to medical and health matters, including compulsory health insurance, have been shelved by the senate labor and public welfare committee and that none will be considered until a special study of such proposals is completed next March 15.

The shelving was achieved by a resolution empowering a special health subcommittee, headed by Smith, of the labor and public welfare committee to continue its study of national health programs through the congressional recess.

A MOMENT OF FORETHOUGHT

Doctors taught the world that *an ounce of prevention is worth a pound of cure.*

Insurance could well rephrase this to be *a moment of forethought is worth years of regret.*

Don't risk being without proper disability insurance. Take a few moments now to be sure your plan of protection is adequate. Your local TIME agent can offer valuable assistance.

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Reciprocity With 18 States on Basic Science Exam

Wisconsin First to Enact Basic Science Law; Board Cites Arrangements for Reciprocity

"To treat the sick is not a right but a privilege—a privilege that must be guarded carefully in the interest of the public."
—Medical Blue Book, 1948

Standing as a guardian of the sick and a watchdog of public health are the basic science laws of Wisconsin. They not only define certain basic qualifications needed by those who desire to treat the sick, but form the basis upon which most of the health laws of Wisconsin are built.

When these laws were passed in 1925 at the request of the State Medical Society, Wisconsin became the first state to enact such controls for guarding the health of its people. The Basic Science law is designed only to provide reasonable certainty that those who treat the sick in Wisconsin possess minimum qualifications in the basic sciences of anatomy, physiology, pathology and diagnosis. Successful passage of the basic science examinations does not authorize a person to treat the sick, but he must have received his basic science certificate before he is permitted to be examined for license to practice any branch of treating the sick.

All persons who treat or attempt to treat the sick must have a basic science certificate except commissioned surgeons of the Army, Navy and federal health service; registered nurses; dentists; optometrists; persons practicing Christian Science or others administering to the sick by mental or spiritual means; masseurs; medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners and persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency.

Examinations in the basic sciences are conducted at least four times a year by the State Board of Examiners in the Basic Sciences. Members of this board are Prof. Michael F. Guyer, University of Wisconsin, president; Prof. W. H. Barber, Ripon College, Ripon, secretary, and Prof. Herbert M. Weeks, Superior State College, Superior.

Those desiring to take the examination must apply to the Board, show evidence of good moral character, preliminary education equal to high school graduation and pay a fee of $10. The applicant does not have to tell the Board the professional school from which he was graduated nor what system of treating the sick he intends to pursue.

The Wisconsin applicant for a basic science certificate must pass written and practical examinations in anatomy, physiology, pathology and diagnosis with a grade of at least 75 per cent in each. If he fails one subject, he may be reexamined in that subject within a year without further fees, but if he fails in two or more, he must wait one year, reapply and be reexamined in all subjects. An applicant who satisfactorily passes the examinations receives the basic science certificate.

Reciprocity Rules

The Board may issue certificates to out-of-state applicants if they produce satisfactory evidence of having passed a basic science examination before a legal examining board of another state with whom Wisconsin has reciprocity relations. States with whom Wisconsin has reciprocity agreements will grant certificates to applicants who have passed the Wisconsin examinations and meet their other requirements.

The basic science board of Wisconsin accepts for reciprocity the certificate of any legally established board. Such boards exist in Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Iowa, Michigan, Minnesota, Nebraska, New Mexico, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Washington and Wisconsin. The attorney general of Wisconsin has ruled that the National Board of Medical Examiners is not a legal board.

Write for Information

Wisconsin has reciprocity agreements with Arkansas, Iowa, Oregon, South Dakota and Tennessee —they accept Wisconsin certificates and Wisconsin accepts theirs. The basic science boards of Colorado, Minnesota and Nebraska accept Wisconsin grades in anatomy, physiology and pathology and then require the candidate to write examinations on the additional subjects in which they examine. In Minnesota the additional subjects are bacteriology, chemistry and hygiene.

Applicants seeking basic science certificates in states with which Wisconsin does not have reciprocity agreements should write to the respective board for specific information regarding their requirements.

Persons holding an M. D. degree while serving in the Medical Corps of the Armed Forces of the United States are entitled to a Wisconsin

(Continued on next page)

Subjects Included in Basic Science Examinations

	Examinations Required in					
	Anatomy	Bacteriology	Chemistry	Hygiene	Pathology	Physiology
Alaska	x	x	x	x	x	x
Ariz.	x	x	x	x	x	x
Ark.	x	x	x	--	x	x
Colo.	x	x	x	--	x	x
Conn.*	x	--	--	x	x	x
Dist. Col.	x	x	x	--	x	x
Fla.	x	x	x	--	x	x
Iowa	x	x	x	x	x	x
Mich.**	x	x	x	x	x	x
Minn.	x	x	x	x	x	x
Nebr.	x	x	x	x	x	x
New. Mex.	x	x	x	--	x	x
Okla.	x	x	x	--	x	x
Ore.	x	--	x	x	x	x
R. I.	x	x	x	--	x	x
S. D.	x	x	x	--	x	x
Tenn.	x	x	x	--	x	x
Wash.	x	--	x	x	x	x
Wis.*	x	--	--	--	x	x

* requires examination in diagnosis.
** requires examination in public health.

HIGH COST OF CONSTRUCTION REVEALED IN PLANS TO BUILD INFIRMARIES FOR AGED

New Buildings for Aged and Chronic Ill Cost $64,000,000

Madison, June 22. — Plans for the construction of county infirmaries to care for the chronically ill and aged infirm are going ahead despite the prospect of high construction costs.

According to preliminary estimates from the state department of public welfare, it would cost $64,000,000 to build the required bed capacity in such institutions. Even these estimates are considered conservative. In addition, it was pointed out that the cost of operating such infirmaries if constructed would run to $20 per patient per week. This is a higher per capita cost than for many other state institutions.

Investigation of construction needs and costs showed that there are more than 12,000 persons in Wisconsin requiring infirmary type care. This would require the provision of about 3.75 beds per 1,000 of general population. The public welfare officials found that at current construction costs of $10,000 per bed, these new buildings would cost more than $64,000,000.

It may be that at present some counties will not be able to participate in such programs as many of them already have serious financial commitments, according to reports. An appeal to the state legislature for funds runs into similar difficulty because of the state's demands on tax funds for other purposes.

The committee on mental hygiene and institutional care of the State Medical society is currently meeting with the Wisconsin County Judges association, the state public welfare department and the Wisconsin County Boards association to present some type of recommendation to the 1949 legislature.

W. O. Cromwell

The director of the recently created Bureau of Alcohol Studies at Madison, Mr. W. O. Cromwell, has reported that the Bureau is making plans to set up an alcoholic clinic in Madison. Plans for the clinic depend upon city and state approval. Mr. Cromwell wrote about alcoholism in the June issue of *The Medical Forum*.

RECIPROCITY—

(Continued from previous page)

basic science certificate upon presentation to the Board of a photostatic copy of the service record or other official certification attesting that fact.

An applicant who is licensed to practice medicine in a state which does not have a basic science board should have the secretary of his state board of medical examiners send to the Wisconsin basic science board a certification, with grades, that he has been licensed to practice medicine (osteopathy) and surgery in that state, that his license has not been rescinded, that he is now in good standing and that he has practiced for at least one year.

A person from a state which has a basic science board may seek a Wisconsin certificate by having the secretary of his state's basic science board send to the Wisconsin board a certification, with grades, that he has passed its examinations and has been granted a basic science certificate, stating the number of the certificate and the date granted.

Health of Nation Not as Bad as Claimed by Socializers—Dr. Goin

Chicago.—A compulsory sickness insurance law will in no way heal the medical economic problems in this country, Dr. Lowell S. Goin, Los Angeles, declares in the June issue of *Radiology*.

"The health of the nation is not as bad as proponents of socialized medicine claim," Dr. Goin states as he points out that America is the last great country in the world where medicine still remains a free enterprise.

Calling attention to a U. S. Public Health Service report, Dr. Goin said that although "the United States has not had the benefits of compulsory sickness insurance . . . the incidence of tuberculosis is less than 25 per 100,000 of population. Great Britain has had compulsory sickness insurance since 1911 and, by strange coincidence, that country's incidence of tuberculosis is between 50 and 75 per 100,000, while in Germany, which has enjoyed these benefits since 1884, the incidence is given as between 75 and 100 per 100,000."

German and English doctors know just as much as we do about diptheria which is a specific disease with a specific treatment, he wrote. Yet in the last year in which there are comparable figures, the death rate in the U. S. was somewhat less than 4 per 100,000 population, while in Germany it was 11.6 per 100,000 and in Great Britain 11.7 per 100,000.

Dr. Goin states that there is no place where public health is as good as it is in this country, "no other country has medical science advanced as much," and European countries have lost their preeminence as educational centers to the U. S.

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In February, 1948, over 86% of the doctors in Great Britain voted against participation in the Labor Government's universal "free" medical service scheme. On May 5, 1948, a second plebiscite showed only 64% of the doctors unfavorable, 25,000 voting against participation and 14,000 for it. The British Medical Association thus did not get a majority of 13,000 of some 20,000 general practitioners to support its previous stand against participation.

* * *

One seventh of our population seems now to be eligible for "life long free hospital care through the Veterans' Administration," declares the *Reader's Digest* of February, 1948. Currently 91 hospitals are being built to supplement 124 already constructed for the care of veterans.

* * *

The upsurge of interest in heart disease has produced results. In 1947 the National Heart Association had only $200,000 to work with. Since then the Keefe bill has resulted in an original appropriation of 2½ million dollars with an additional emergency appropriation of one-half million. The association itself has received another one million dollars from the Ralph Edwards "walking man" contest.

* * *

The House of Representatives has passed S. 1470 providing hospital care for National Guardsmen and Reservists who are injured or become ill during training.

* * *

Congress wound up its session by allocating a minimum of $100,000 per fiscal year to each state for hospital construction under the Hill–Burton bill. Its chief effect was to provide more money for states like Nevada and Florida and to make greater amounts available to the Virgin Islands.

Seven States Certify Chiropractors in Basic Sciences

Chicago, June 12.—A survey of the medical licensure statistics for 1947 reveals that 3,615 candidates for basic science certificates were examined by 19 basic science boards during the year, according to the AMA Council on Medical Education and hospitals headed by Dr. Donald G. Anderson.

The majority (3,132) represented physicians or medical students, 147 were osteopaths, 61 chiropractors and 198 unclassified. The latter group included osteopaths, naturopaths, chiropractors and others not identified by reference material.

Forty-two of the 61 chiropractors (68.9%) examined failed to pass the examinations. Forty-three per cent of the unclassified group failed, 34% of the osteopaths and 23.2% of the doctors and medical students.

Chiropractors appeared for certification before the boards of Arizona, Connecticut, Florida, Iowa, Michigan, Minnesota, South Dakota, Washington and Wisconsin. Twelve of the 19 basic science certificates issued to chiropractors were issued in Wisconsin. Arizona, Connecticut, Michigan, Minnesota and Washington issued one each and Iowa issued two. Thirteen chiropractors received basic science certificates by reciprocity, endorsement or waiver—five in Arizona and Colorado and one each in Michigan, South Dakota and Wisconsin.

PLAN CLINICS FOR CRIPPLED CHILDREN

Madison, July 1.—A series of 13 orthopedic field clinics are being held during the next five months under the sponsorship of the Crippled Children Division of the State Bureau for Handicapped Children.

Parents and physicians are invited to attend the clinic with any child, under 21 years of age, "whose condition can probably be remedied or advantageously treated by orthopedic surgery or other special surgical and medical care."

Family physicians are requested to make the referrals to these clinics, but parents may make arrangements by writing the Bureau. The clinics will be held at Lancaster, July 2; Chippewa Falls, July 23; Ashland, August 20; Wausau, August 26–27; Manitowoc, Sept. 3; Kenosha, Sept. 15–16; Racine, Sept. 23–24; Superior, Oct. 1; Green Bay, Oct. 12–13–15; Eau Claire, Oct. 18–19; Sheboygan, Oct. 28–29; Appleton, Nov. 11–12 and La Crosse, Nov. 17–18.

Referral forms may be obtained from the Bureau for Handicapped Children, 146 North, Capitol, Madison 2, Wisconsin, and should be requested in advance of the clinic date.

W. F. Doscher

DOSCHER TO AID PUBLIC RELATIONS

Former Wisconsin Resident

Chicago, June 1.—Public relations services of the American Medical Association to state and county medical societies will be increased as the result of the appointment of Mr. William F. Doscher as assistant director of public relations in the office of Lawrence W. Rember, executive assistant in charge of public relations.

Doscher began work with the AMA on April 26 and will devote a major portion of his time to the development of the field public relations program of the Association. He was director of the community relations projects of the Manufacturers Association of Kenosha, Wisconsin, and has had more than 10 years experience in the public relations field. He will be available for speaking appearances and consultation on public relations matters.

Supplement to Red Book Fee Schedule

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

Tear Out and Attach to Your Red Book Fee Schedule

Effective July 1, 1948 the Wisconsin Veterans Medical Service Agency and the Veterans Administration have agreed on the following changes and additions to the present *Red Book fee schedule.* Please attach this schedule of fees to your *Red Book fee schedule.*

These fees are maximum fees and are not to be used in every case. The Veterans Administration is willing to pay the prevailing fee in the care of veterans but will not pay more to a physician for the care of veterans than the physician charges non-veterans. When sending your bill to us on form 200 please fill in the amount of your charges. Particular notice is directed to Visits and Examinations code numbers 0013 through 0021.

VISITS AND EXAMINATIONS

Office, home or hospital visits, including examination to determine need of hospitalization

Visits within city limits

Day: 8:00 a. m.–7:00 p. m.	0013	Office	$ 3.00
	0015	Home	4.00
	0017	Hospital	4.00
Night: 7:00 p. m.–8:00 a. m.	0019	Home	7.00
	0021	Hospital	7.00

0012—Complete general routine physical examination including routine urinalysis — 7.50

0023—Charge for mileage one way for day or night visit, including examination to determine need of hospitalization outside city limits in addition to appropriate fee — 0.75

0028—Physical Examination of Chest (this will include the heart) — 5.00

0055—Other comparable specialties not listed above: First visit — 5.00

0056—Other comparable specialties not listed above: Each Subsequent visit — 3.00

0627—Bromsulfalein excretion test — 2.00

0628—Hippuric Acid — 4.00

0629—Cephalin — 3.00

0630—Thymol Turbidity — 3.00

0631—Icterus Index — 2.00

1019—Thrombotic Hemorrhoid (Includes pre & post-operative treatment) — 10.00

2325—Injection of Trigeminal Nerve Individual branch — 10.00

2326—Injection of Sciatic Nerve — 15.00

2327—Injection of Sympathetic Ganglion — 15.00

4704—Tumor or cyst ..... $ 10.00
5025—Urethral Dilatation, with or without local anesthesia 5.00
5026—Prostatic massage, per treatment 3.00
5027—Prostatic massage plus physical therapy, per treatment 5.00
5028—Bladder irrigation, per treatment 3.00
5029—Fulgeration of venereal warts, per treatment 3.00
5528—Application of cast to the arm in hospital requiring no manipulation 10.00
5529—When physician furnishes his own cast material 15.00
5530—Application of cast to the foot in hospital requiring no manipulation 15.00
5531—In office, no manipulation 20.00
8116—Therapy, electroshock or metrazol, per treatment, to include medication, curare, etc., as employed 15.00

RADIATION THERAPY

9100—Original consultation 10.00
9101—Follow-up consultation 3.00
9102—Superficial therapy (infections, inflammations) per treatment 5.00
9103—Sinusitis, bursitis, per lesion: Course of treatment 25.00
9104—Skin malignancies, per lesion: Course of treatment (lip, eyelid, and orifices excluded 75.00
9105—Malignancy of the lip, eyelid, orifices, per lesion: Course of treatment 150.00
9106—Carcinoma of the cervix uteri
Radium therapy: Complete course $100.00
Roentgen therapy, external:
Complete course ..... $150.00 Total 250.00
9107—Carcinoma of the cervix uteri
Roentgen ray therapy, including external and intravaginal or equivalent:
Complete course 250.00
9108—Carcinoma larynx, lesion: Course 200.00
9109—Carcinoma pharynx, lesion: Course 200.00
9110—Malignant bone lesions, lesion: Course 175.00
9111—Malignant soft tissue lesions; per lesion; Course 150.00
9112—Malignancy of eye or orbit, lesion: Course 200.00
9113—Hyperthyroidism, lesion: Course 100.00
9114—Fibromyoma uteri, menorrhagia, lesion: Course (radium or roentgen therapy) 75.00
9115—Malignancy, inaccessible organs, lesion: Course (lung, kidney, prostate, bladder, thyroid, esophagus, stomach, brain) 150.00
9116—Malignancy, breast, lesion: Course Postoperative—Preoperative, each 125.00
9117—Lymphoblastoma, leukemia, Hodgkin's disease, per treatment, per area 10.00
Maximum of $200.00 per course
9118—Conditions not above included, per treatment, Deep Therapy 10.00

THOS. J. DORAN, *Director*

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A. R. ZINTEK

Doctor Zintek, a native of Milwaukee, received his M.D. degree from Marquette University in 1934. He joined the state health department in 1941 as a state district health officer. Last year he completed three years of postgraduate work at the University of Michigan, for which he received the degree of D.P.H., and on his return to the department was named director of preventable diseases.

Elective Tonsillectomies During Summer Months

The onset of warm weather is always accompanied by the threat of epidemic poliomyelitis occurring in either limited areas or widespread throughout the state of Wisconsin. At this time of the year, the question is repeatedly asked as to the necessity or the justification for the postponement of performing elective tonsillectomies. The literature contains many references to the dangers that are involved in such a procedure. Kessel and Moore have called attention to the fact that not infrequently tonsils of apparently well children, removed during interepidemic periods, were actually harboring the virus of poliomyelitis and that when these tonsils were ground up and inoculated intracerebrally into monkeys it was possible to produce the experimental disease. In their series, 3 per cent of the children whose tonsils were removed were harboring virus, and the authors suggest that the number of carriers far exceeds the number of recognized cases. Francis, Toomey, Krill, and Mack have reported a family of children who presumably were harboring the virus of poliomyelitis in their throats, and following tonsillectomy 3 youngsters came down with bulbar poliomyelitis and died. A fourth came down with a spinal paralytic form of the disease. The fifth child of this family, who was demonstrated to harbor the virus but did not have a tonsillectomy performed, failed to have any clinical manifestations of poliomyelitis develop. Faber, Dong, and Silverberg have called attention to the throat and upper portion of the esophagus as an important route for the pathogenesis of the experimental disease. It has been suggested that the trauma associated with dental surgery may be important in the penetration of the virus into the central nervous system.

The critical experiment to demonstrate that these phenomena have a cause and effect relationship still remains to be done. The incidence of diagnosed and reported poliomyelitis remains at a relatively low level and makes it difficult to be certain that such an association is more than just coincidence. The frequency with which tonsillectomies are done in children during the summer months is so great that one would be surprised if the disease did not follow in a certain number. The information, which is lacking, is one of comparing the risk of development of the disease among tonsillectomized children and those who have not been subjected to such trauma. If it can be demonstrated that this risk is significantly greater than that of the general population, then, of course, elective tonsillectomies should be postponed. Until the time as such information is available, it will not be possible to draw sound conclusions. An effort is being made, at the present time, to obtain this information on a national scale.

In the meantime, considerable publicity and lay education have occurred in popular periodicals. The problem of poliomyelitis carries such a wide interest to so many parents and has become the theme of many articles written for popular magazines. As a result, the popular notion that elective tonsillectomies during the poliomyelitis season is contraindicated is very widespread. The surgeon must carefully consider the impact of this popular opinion in his decision to perform a tonsillectomy during the summer months of the year.—AUTHUR R. ZINTEK, M.D., *Director, Preventable Diseases.*

EMERGENCY MATERNITY AND INFANT CARE PROGRAM

The Bureau of Maternal and Child Health, Wisconsin State Board of Health, is issuing an SOS to physicians who have not returned summaries and vouchers on patients for whom they requested care. EMIC is new in final process of liquidation.

The last *maternity patients* eligible for care were those who became pregnant prior to July 1, 1947 and whose husbands were in one of the four lowest pay grades prior to July 1, 1947, but within the period of pregnancy. Only infants born under EMIC remain eligible for care up to their first birthday.

Cases on which care has been completed must definitely and finally be closed. Payment must either be made or encumbered funds released. This is the last call for reports. Physicians should check through their records and file the forms which they hold.

As It Looks From the Committee on Rural Medical Service of the American Medical Association

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a mid-western state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.

VIRGINIA SHULER

For the past ten years, Mrs. Virginia Shuler, secretary of the AMA Committee on Rural Medical Service, has worked closely with state medical society organizations. Prior to coming to the AMA, she did field survey work with the United States Public Health Service and served during the war as field analyst for Procurement and Assignment Service. She originally joined the staff of AMA in 1944 to establish and direct the Bureau of Information for Medical Officers.

Often the question is asked, "Is there a trend now for physicians to locate in rural communities?" From our experience in helping hundreds of returned medical officers to settle after World War II, the answer is "Yes." We have no difficulty in interesting physicians to set up practice in areas of over a thousand population, provided there are nearby hospital facilities. Our attention must be directed to the many towns of under a thousand population throughout this country that have voiced their need for a general practitioner.

These are the communities the state medical societies should survey to determine how adequately the towns are serviced at present. With this information the medical profession, with the help and support of the communities, can work out a coordinated system to extend better medical service to the rural population.

Some states are organizing community clinics to service several small areas which alone are not large enough to support a physician. These community clinics, branching from a nearby rural hospital, should be carefully considered as a means of creating a more coordinated system of health and medical service for our towns of a few hundred population. Where medical personnel is not available, the rural hospital and the nearest medical school should try to work out through their personnel medical service for these rural people. The active programs the medical schools in the various states are developing to bring the advantages of urban practice to rural physicians will be a leading factor in attracting physicians to the rural areas.

In this way we are laying the groundwork for our responsibilities in rural health which may be summed up as follows:

1. To assure competent physicians for every area in the United States wherever the area is able to maintain a physician.
2. To have up-to-date information regarding the distribution and need for physicians in every area.
3. To make certain that the areas have adequate laboratory and hospital facilities, so that the rural physician may practice good medicine.
4. To extend to the rural physician the advantages of urban practice through postgraduate courses, clinical conferences, and consultant services.
5. To make the physicians' services available to every individual through prepayment plans.
6. To explore ways and means to insure that a high standard of medical service is delivered by cooperatives, clinics, and health and welfare plans, such as those of the United Mine Workers and the United Auto Workers of the Congress of Industrial Organizations.
7. To work with other groups in developing programs that will assure the citizen of tomorrow a happy, healthy future.—MRS. VIRGINIA SHULER, *Secretary, Committee on Rural Medical Service.*

. . . . THE PRESIDENT'S PAGE . . . .

Student Opinion

A FEW nights ago I had the pleasure of joining a long "bull session" with a small group of residents and senior medical students. The topic discussed was rural medical practice and the general practitioner. I was mostly a listener and inquirer.

The subject was opened by one student who remarked, "The profession in general and the public, judging by comments in current medical journals and lay magazines, are somewhat disappointed with and in some cases incensed by medical students because they choose to specialize rather than to join the ranks of the general practitioner."

In his opinion most of the concern is expressed by those who have already specialized and feel the need of someone to perform the less responsible duties of medical practice for those who need minor medical service or who will recover without any. When reminded that it is from this group that serious disease is recognized early and among whom preventive medicine has its greatest effectiveness, it was his opinion that those whose conditions are not serious enough to pass on to the specialist are not concerned enough to follow the advice necessary to accomplish prevention. In this situation he said the general practitioner becomes a sign post, a traffic cop, directing the interesting cases and remunerative practice to the specialists who live in large centers of population.

At this point the whole group was in the discussion expressing varying ideas. But, it was apparent that they were all of the opinion that the general practitioner today does not occupy the place of prominence that he did a decade or two ago; that the science of medicine is so rapidly becoming a quality of the art of medicine that the physician equipped only with a stethoscope, fleximeter, and sphygmomanometer can no longer satisfy the standards of medical practice set by technics which involve more complicated apparatus. They were all convinced that specialization is necessary if the potentially serious cases are to be separated from those who need less urgent medical care in time to prevent serious complications and debilitating disease.

They asked the following question: What do people living in rural areas want? Do they want especially trained doctors? Will they accept general training in lieu of special training? Is the training now provided for those wishing to do general practice adequate to equip the young doctor for the practice of modern medicine? These and many other questions were brought into the discussion. One student expressed the idea that preventive medicine can be practiced only where there are adequate laboratory facilities, because many of the implements needed for early diagnosis and adequate treatment are found only in well equipped laboratories and in hospitals. They said that if these are provided in rural areas, the specialist has the same opportunity to practice there as in the city. It was pointed out that physicians are needed in areas where general hospital facilities cannot be maintained and even in urban communities a physician who can and will do general practice is badly needed.

It was an interesting evening. These young men who have acquired years of premedical and medical training were thinking hard of the kind of medical care that is needed and the quality of training that is required of those who supply it. They were in a quandary about the problem. They saw many of the difficulties. They realize that the general practitioner does not have the professional prestige that he has had in former years or as compared with those who specialize and that his hours are long and his work difficult. They feel that his compensation is not commensurate with those who have shorter hours and no more responsibility. They believe that gilding the lily, flattering the general practitioner about his importance and the great service which he renders, will not be successful in inducing any large number of young physicians to enlist in this service. Nor do they think that exhortation by educators and others who themselves have not chosen this field will succeed in filling the ranks of this much needed group of doctors.

At the end, the discussants seemed to agree that students of medicine will continue to choose special fields in which to practice and in increasing numbers; that they can bring a high type of medical care to people in the smaller communities and satisfy their own ambitions by practicing in groups; that medical educators in schools and hospitals must provide more specialized training for those who are to practice general medicine; that the profession must provide through group practice or by other means an opportunity for those especially trained general practitioners to share equally in rank and remuneration with their more highly specialized confreres. They thought that nothing short of this will succeed in attracting good students into the field of general medical practice.

W D Stovall

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« « « EDITORIAL » » »

Introducing the Guest Editorialist

This busy general practitioner is not likely to be pictured bouncing down a country road to make late afternoon rounds of patients 25 or 30 miles apart. While many of his problems are the same as his country counterpart, Doctor Griffith of Milwaukee practices general medicine in close proximity to more than half a million potential patients and more than a thousand others of his own profession. A high percentage of his colleagues are specialists. And this concentration includes hospital and medical facilities of every sort as well as hundreds of nurses, residents, and interns.

Doctor Griffith writes to point out the need for understanding and cooperation within the medical profession, so that more American people may have the best medical care that is delivered anywhere.

When he speaks of the relationship of the general practitioner and the specialist to giving medical service to the greatest number of people, he meets the issue head on. He writes as a "GP" and a general surgeon at St. Mary's and Misericordia hospitals, and from his experience in industrial practice in a highly industrialized city. He draws upon his knowledge of the problem as an instructor at Marquette University School of Medicine, his alma mater. He writes, too, as the spokesman for his fellow practitioners who have seen fit to honor him with the position of president of the Medical Society of Milwaukee County.

The Practitioner and the Diplomate

TO BRING the best possible medical service to the greatest number of people is a problem that is before the American doctor today. While many doubt that a shortage of doctors exists, at least there is the prospect of no immediate increase in their numbers for many years to come if the standards of medical education are to be kept high. It has been the aim of the profession and the medical schools to improve constantly both undergraduate and postgraduate education.

Some educators have been heard to say recently that in an ideal American system of medicine, in the future, all doctors would be specialists; the patient would consult first the internist, and he, after an examination, would refer the ill person to the proper specialist for further care.

It is questionable whether this is practical; it certainly isn't possible with the number of hospitals that can be approved for training that would lead to certification in the specialties and still keep the standards high. Good training must be recognized, and certification as a diplomate is, without a doubt, the way to do it.

The desire for the young man to undergo this training has been popularized by the recognition given the diplomate by the medical school, the military services, the Veterans Administration, the insurance companies, and almost everyone except the greater part of the public.

The young diplomate, especially in surgery, after his years of training has had difficulty in finding enough patients on whom to operate. The general practitioner who has gained the confidence of the people among whom he practices, even though he may have an adeptness and training in some phases of surgery and plenty of patients who want no one but him to operate on them, has no hospital in which to operate.

The general practitioner has felt that one hospital after another has been closed to him as far as any surgery or major obstetric procedure is concerned. He has been denied the teaching privileges of which he is capable, and he has no opportunity for advancement in any ward or clinic service.

The situation has not been helped by the journalistic and national radio discussion in the past year, which gave the statement that of the 14,000,000 people entering United States hospitals about one half were admitted for some kind of operation; or by the statement that very many of these operations should never have been performed and that many undoubtedly were performed by surgical bunglers. Statements were quoted from university professors and others that if the patient were to be assured that he would not be operated on unnecessarily and subjected to mayhem and even manslaughter, he should choose a surgeon who is a diplomate of the American Board of Surgery or a Fellow of the American College of Surgeons.

This impression given to the American public is unjust, unfair, and untrue. It has the sound of propaganda, and it tends to build up a resistance to a system of certification of specialists well conceived and initiated and intended to be best for the public and the doctor.

This impression is unjust to a large group of capable and experienced American surgeons, outside of the Board and College of Surgeons, who have done much to advance the standards of American surgery through the years.

It is unfair to the honest general practitioner. He has always had the welfare of his patient at heart, and, finding that he is able to do more than one thing well, he takes postgraduate work so as to serve better those who entrust their lives to him. He would not think of performing any operation that was unnecessary or attempt one of which he is incapable.

The impression is untrue if the greatest part of surgery is performed in the hospital, where all tissues removed are examined by a pathology department and the work of all those doing surgery is scrutinized by those most capable of judging any man's capabilities and limitations, his own hospital staff. The way and the means of both helping and disciplining the doctor are available to the hospital staff, and the staff should be firm and fair in this regard.

Misunderstanding is building up a resistance against the sound, well trained young diplomate in many communities and hospitals, because of the fear that he will seek only to control the staff to which he is appointed, to the exclusion of older experienced men.

The American people enjoy a higher quality of professional and surgical care than anyone else in the world. Cooperation within the medical profession will put a continuing emphasis upon this fact.

J. C. Griffith, M. D.

Annual Meeting Timetable

★ SUNDAY, OCTOBER 3 ★

p. m.
3:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder

★ MONDAY, OCTOBER 4 ★

a. m.
7:30 Registration: Main Arena, Milwaukee Auditorium
9:00 Clinical Conferences: Milwaukee Children's Hospital
Milwaukee County Hospital
Veterans Hospital, Wood

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
6:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
8:30 Informal Smoker and Entertainment: Crystal Ballroom, Hotel Schroeder

★ TUESDAY, OCTOBER 5 ★

a. m.
9:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
5:30 President's Reception for those attending Annual Dinner: Banquet Room, Fifth Floor, Hotel Schroeder
6:45 Annual Dinner: Crystal Ballroom, Hotel Schroeder

★ WEDNESDAY, OCTOBER 6 ★

a. m.
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 Section Meetings: Milwaukee Auditorium
General Practice: Engelmann Hall
Internal Medicine: Plankinton Hall
Obstetrics & Gynecology: South Juneau Hall
Ophthalmology & Otolaryngology: North Juneau Hall
Pediatrics: North Kilbourn Hall
Radiology: Walker Hall
Surgery: South Kilbourn Hall

Guest Speakers

STATE MEDICAL SOCIETY of WISCONSIN
1948 Annual Meeting
MILWAUKEE · OCT · 4 · 5 · 6

NORMAN H. TOPPING
Bethesda, Md.
General Program, Monday

J. B. YOUMANS
Chicago
General Program, Monday
Section on Internal Medicine, Wednesday

M. E. DEBAKEY
New Orleans
General Program, Tuesday
Section on Surgery, Wednesday

H. W. BROSIN
Chicago
General Program, Monday

ARNOLD GESELL
New Haven, Conn.
General Program, Tuesday
Section on Pediatrics, Wednesday

EVARTS A. GRAHAM
St. Louis, Mo.
General Program, Monday

O. H. WANGENSTEEN
Minneapolis
General Program, Wednesday
Section on Surgery, Wednesday

R. H. FREYBERG
New York City
General Program, Tuesday
Section on Internal Medicine, Wednesday

J. L. Baer
Chicago
General Program, Tuesday
Section on Obstetrics and Gynecology, Wednesday

G. E. Shambaugh, Jr.
Chicago
Section on Ophthalmology and Otolaryngology, Wednesday

W. A. McGee
Richmond, Va.
Section on Pediatrics, Wednesday

A. D. Prangen
Rochester, Minn.
Section on Ophthalmology and Otolaryngology, Wednesday

R. L. J. Kennedy
Rochester, Minn.
Section on Pediatrics, Wednesday

Frank Whitacre
Memphis, Tenn.
Section on Obstetrics and Gynecology, Wednesday

B. R. Kirklin
Rochester, Minn.
General Program, Wednesday
Section on Radiology, Wednesday

F. A. Gibbs
Chicago
Section on Pediatrics, Wednesday

H. M. Murdock
Towson, Md.
General Program, Tuesday
Section on General Practice, Wednesday

July Nineteen Forty-Eight

WE ANTICIPATE A *Shortage!*

The Wisconsin Pharmaceutical Association is meeting at the Hotel Pfister the same days as our Annual Meeting. This, plus heavy commercial travel, will mean a scarcity of rooms. RESERVE YOURS NOW ON THE FORM BELOW. Remember: If you are a delegate, councilor or officer, start your reservation Saturday, October 2, as the first session of the House of Delegates is Sunday afternoon. Scientific sessions are on Monday, October 4, through Wednesday, October 6. Reserve for the entire time, as the 1948 program is exceptionally strong, right up to 5:30 p. m., Wednesday.

Headquarters, meetings of the House of Delegates, Round-Table Luncheons, and the Annual Banquet will be held at the Hotel Schroeder.

Hotel Medford:

Single without bath	$1.75	
Single with bath	2.50 to	$3.25
*Double without bath (*toilet and lav.)	3.25 to	3.50
Double with bath	3.50 to	4.50
Twin without bath	3.50 to	---
Twin with bath	5.00 to	6.00

Hotel Pfister:

Single without bath	$2.75 to	$4.40
Single with bath	3.30 to	7.70
Double without bath	4.95 to	6.60
Double with bath	5.50 to	9.90
Twin without bath	4.95 to	6.60
Twin with bath	5.50 to	9.90

Plankinton House:

Single without bath	$ --- to	$ ---
Single with bath	3.30 to	5.50
Double without bath	--- to	---
Double with bath	4.50 to	6.60
Twin without bath	--- to	---
Twin with bath	5.50 to	8.80

Randolph Hotel:

Single without bath	$2.00 to	$ ---
Single with bath	2.50 to	3.50
Double without bath	3.25 to	---
Double with bath	3.75 to	5.50
Twin without bath	None	
Twin with bath	5.00 to	5.50

Hotel Schroeder:

Single without bath	$2.75 to	$ ---
Single with bath	3.50 to	7.70
Double without bath	--- to	---
Double with bath	6.00 to	8.80
Twin without bath	--- to	---
Twin with bath	7.00 to	12.00

Hotel Wisconsin:

Single without bath	$1.75 to	$2.00
Single with bath	3.00 to	6.00
Double without bath	2.75 to	3.00
Double with bath	4.25 to	7.50
Twin without bath	None	
Twin with bath	6.00 to	9.00

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Mail This Coupon to Hotel Selected

Manager, _____ Hotel, Milwaukee, Wisconsin.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the State Medical Society of Wisconsin, October 4, 5, and 6, 1948, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite ☐ Other _____

Arriving October _____ at _____A. M. _____P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Society Proceedings

Calumet

Members of the Calumet County Medical Society met at Brillion for a business meeting on June 8. Among the subjects discussed were the Society's pledged support for the erection of a hospital for Calumet County and a hearing program sponsored by the State Board of Health to be conducted among school children in the county.

Dodge

The community diagnostic services at Juneau were explained to members of the Dodge County Medical Society for two staff members at a meeting at Hotel Rogers, Beaver Dam, on May 27. *Dr. Joseph E. Weber* of Milwaukee, a psychiatrist, and Miss Eunice Matthewson of Madison, a psychologist, described the work of the clinic in aiding children who are maladjusted or who present an emotional problem.

Fond du Lac

Directors of two agencies of the State Medical Society spoke at the Fond du Lac County Medical Society when it met at the Hotel Retlaw in Fond du Lac on May 20. Mr. Thomas J. Doran discussed the activities of the Wisconsin Veterans Medical Service Agency, and Mr. Ralph Weber explained the work of Wisconsin Physicians Service.

Green Lake—Waushara

Meeting at the Club House in Berlin on June 17, members of the Green Lake–Waushara County Medical Society heard talks by *Drs. W. S. Middleton* of Madison and *H. H. Christofferson* of Colby. Doctor Middleton, who is dean of the University of Wisconsin Medical School, presented a paper on "Some Recent Advances in the Therapy of Coronary Disease." Councilor for the Ninth District, Doctor Christofferson discussed "Current Trends Toward Compulsory Health Insurance."

Iowa

Three members of the staff of the University of Wisconsin Medical School were guest speakers of the Iowa County Medical Society when it met at the Dodge–Point Golf Club in Dodgeville on May 20. *Dr. Kenneth B. McDonough*, assistant professor of pediatrics, discussed "Growth Problems in Children"; *Dr. Herman Wirka*, associate professor of orthopedic surgery, spoke on "Fractures of the Elbow in Children"; and *Dr. Kenneth E. Lemmer*, associate professor of surgery, pointed out "Some Surgical Aspects of Gall Bladder Disease." Election of officers was held, and the financial report was presented by the treasurer.

Jefferson

Forest Lawn Sanatorium in Jefferson was the meeting place for the Jefferson County Medical Society on May 20. Tuberculosis was the subject for discussion for the evening. *Doctor A. A. Pleyte*, Milwaukee, the guest speaker, emphasized the diagnostic aspects of the disease, illustrating his talk with films showing the various types of pulmonary pathology. *Dr. A. R. Zintek*, Madison, director of the Bureau of Communicable Diseases of the State Board of Health, also was present to exhibit slides concerning tuberculosis in Wisconsin. *Dr. A. A. Busse*, director of Forest Lawn Sanatorium, who arranged the program, entered into the discussion and also demonstrated slides and a number of patients. Members of the Society were dinner guests of the staff of the sanatorium.

Outagamie

Guest speaker at the May meeting of the Outagamie County Medical Society was Dr. Willis J. Potts, surgeon-in-chief of Children's Memorial Hospital, Chicago, and associate professor of surgery at Northwestern University Medical School. The meeting followed a dinner at the Conway Hotel, Appleton, on May 21. Doctor Potts, who is a well known pediatric surgeon throughout the midwest, presented a paper entitled "The Diagnosis and Surgical Treatment of Congenital Heart Disease."

Racine

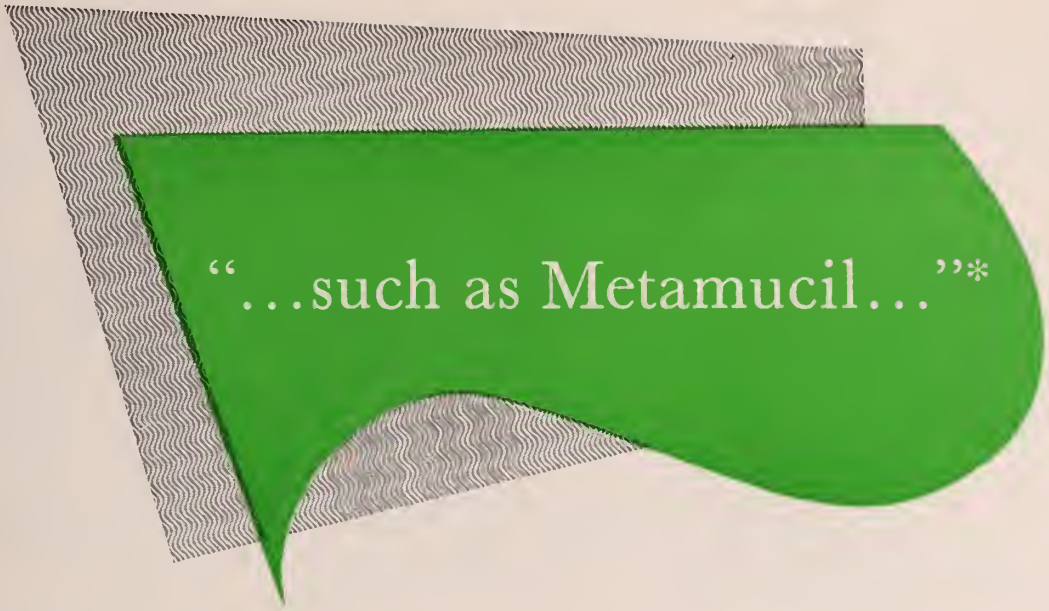
Two Milwaukee physicians were guest speakers at the Racine County Medical Society on May 20, when it met at the Racine County Club. *Dr. F. J. Hofmeister* discussed "The Causes of Premature Delivery," and *Dr George F. Kelly* spoke on "The Care of the Premature Infant." *Drs. Henry Barina* and *H. C. Miller* were appointed to represent the Society on the Racine Welfare Council

Rock

Meeting at the Beloit Country Club on May 25, members of the Rock County Medical Society heard a talk by *Dr. William S. Middleton*, dean of the University of Wisconsin Medical School. Doctor Middleton pointed out the "Newer Aspects of Cardiology."

Washington—Ozaukee

"Early Diagnosis of Cancer" was the subject of a talk by *Dr. Joseph Gramling, Jr.*, Milwaukee at the May meeting of the Washington–Ozaukee County Medical Society. The group met at the Club Zircon in Cedarburg on May 27.



For the treatment of the spastic colon the author suggests diet, elimination of the nervous element and "bulk producers." As examples of these he lists "agar-agar, in finely powdered form, in flakes, or in cereal-like form; derivatives of psyllium seed, such as Metamucil . . . ."*

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*Glafke, W. H.: Spastic Colon, M. Clin. North America 26:805 (May) 1942.

†Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. P. Lippincott Company, 1947, p. 320.

Prescribe Journal-advertised products and you prescribe the best.

Winnebago

Dr. Kenneth Karr, professor of medicine at Marquette University School of Medicine, spoke at a meeting of the Winnebago County Medical Society at the Athearn Hotel in Oshkosh on June 3. He presented the topic "Differential Diagnosis of Coronary Heart Disease and Gallbladder Disease."

Fifth Councilor District

Fred Hines, Ph. D., consultant in health and sickness of the Bureau of Health Education of the American Medical Association, was the dinner speaker at the Fifth Councilor District meeting held at Hotel Manitowoc in Manitowoc on June 17. He spoke on "Physicians and Schools," pointing out the role of the physician in the school health program and ways in which the auxiliary can cooperate in developing the program. Mr. C. H. Crownhart, executive secretary of the State Medical Society, also was on the dinner program, the subject of his discussion being "Medical Economics."

At the business session following the dinner, *Dr. Richard G. Edwards* of Kewaskum was elected president of the district, to succeed *Dr. Edgar Huth* of Valders. *Dr. R. S. Fisher*, Allenton, was named secretary, succeeding *Dr. Nelson Bonner* of Manitowoc.

The scientific program held during the afternoon was presented as follows:

"Carcinoma of the Stomach"
Dr. Joseph Shaiken, assistant clinical professor of medicine, Marquette University School of Medicine

"Acne and Acne Therapy"
Dr. G. A. Cooper, associate professor of dermatology, University of Wisconsin Medical School

"Problems of Prematurity"
Dr. F. R. Janney, professor of pediatrics, Marquette University School of Medicine

"Rheumatic Fever"
Dr. S. F. Morgan, associate clinical professor of pediatrics, Marquette University School of Medicine

"Ulcerative Colitis: Diagnosis and Treatment"
Dr. Joseph Shaiken, assistant clinical professor of medicine, Marquette University School of Medicine

Sixth Councilor District

Physicians of the Sixth Councilor District gathered at the Crystal Ballroom of the Hotel Northland in Green Bay on June 12 for their annual meeting.

Dr. W. D. Stovall, Madison, president of the State Medical Society, was the guest speaker at the dinner, taking the "Philosophy of Science" as his topic for discussion.

Speakers on the scientific program presented during the afternoon were Dr. H. W. Michelson, professor of dermatology at the University of Minnesota Medical School, who discussed "Dermatology for General Practitioners"; Dr. F. J. Hodges, professor of radiology at the University of Michigan Medical School, who spoke on "Radiology in Medical Practice"; *Dr. J. S. Hirschboeck*, dean of Marquette University School of Medicine, who explained "The Differential Diagnosis of Enlargements of the Spleen"; and *Dr. M. J. Musser*, professor of medicine at the University of Wisconsin Medical School, discussing "The Psychosomatic Patient."

Ninth Councilor District

Dr. Henry Meyerding of the Mayo Clinic, Rochester, Minnesota, and *Dr. Ovid O. Meyer* of Madison were guest speakers at the meeting of the Ninth Councilor District held at the Hotel Whiting in Stevens Point on May 27. Doctor Meyerding presented "Comments on Shoulder Disabilities," and Doctor Meyer, who is professor of medicine at the University of Wisconsin Medical School, spoke on "The Prophylaxis and Treatment of Thrombosis."

Wisconsin Surgical Club

Members of the Wisconsin Surgical Club met at the Pember–Nuzum Clinic in Janesville on June 12. During the morning a surgical conference was held at Mercy Hospital; a noon luncheon was served at the Country Club. At the scientific program, papers were presented by seven Janesville physicians and by *Dr. Erwin Schmidt* of Madison. Subjects discussed were "Cryptorchidism" by *Dr. John Schroeder;* "Ambulatory Blood Bank" by *Dr. H. C. Danforth;* "Traumatic Rupture of the Urinary Bladder," by *Dr. S. A. Freitag;* "Application of Nuclear Physics to Medicine" by *Dr. M. M. Baumgartner;* "Management of the Ruptured Intervertebral Disc" by *Dr. G. L. Thomas;* "Medical and Surgical Problems" by *Dr. T. O. Nuzum;* "Benign Lesions of the Esophagus" by *Dr. T. J. Snodgrass;* and "Carcinoma of the Esophagus" by *Dr. Erwin Schmidt.*

UNIVERSITY OF WISCONSIN ANNOUNCES SYMPOSIUM ON STEROID HORMONES

A symposium on steroid hormones will be held on September 6, 7, and 8 as a part of the University of Wisconsin centennial celebration. A number of departments of the university and related groups are combining to present the symposium, and the National Research Council and the Alumni Research Foundation are underwriting certain of the expenses in connection with it. Such well known scientists as Drs. Louis Fieser, Konrad Dobriner, Eleanor Venning, Seymour Lieberman, and Dwight Ingle have accepted invitations to speak.

Accommodations for those who are interested in attending the entire symposium will be available at the Elizabeth Waters Dormitory on the University of Wisconsin campus and will include room and board for $16.25. Reservations may be made with Dr. Henry Lardy, Biochemistry Department, University of Wisconsin, Madison 6, Wisconsin.

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News Items and Personals

Dr. G. J. Hathaway Accepts Position at Veterans Hospital

G. J. HATHAWAY

A Superior physician for twenty-five years, *Dr. George J. Hathaway* recently accepted the position of assistant surgeon at the Grand Army Home hospital, King. He succeeds *Dr. George Schlenker*, who has resumed private practice in Amherst.

Doctor Hathaway, a veteran of both World Wars, has been chief medical officer of the Veterans Administration regional office in Superior for the past year and a half.

Succeeding Doctor Hathaway in Superior will be Dr. Edward G. Stack, Jr., formerly of Chicago. Doctor Stack is a graduate of Marquette University School of Medicine and interned at Misericordia Hospital in Milwaukee.

Hospital in Cuba City Opened by Dr. C. S. King

Opened to public inspection on June 6 was Dr. King's Hospital in Cuba City, owned and operated by *Dr. C. S. King*. The building houses facilities for ten beds and a nursery in addition to treatment, consultation, and examining rooms. Doctor King is a graduate of Hahnemann Medical College in Philadelphia and came to Cuba City in 1947 following his discharge from the Army Medical Corps with the rank of major.

Theda Clark Memorial Hospital Staff Names New Officers

Dr. A. P. Graham, Neenah, was recently named president of the staff of Theda Clark Memorial Hospital in Neenah. Other officers elected were *Drs. G. R. Anderson*, vice-president, and *J. P. Canavan*, secretary-treasurer, also of Neenah.

Manitowoc Society Honors Doctor on Completion of Half Century of Practice

Dr. F. W. Hammond, completing fifty years in the practice of medicine, was honored by the Manitowoc County Medical Society at a dinner at Hotel Manitowoc on May 27. A physician in Manitowoc for thirty-four years, Doctor Hammond moved there in 1914 after sixteen years of practice in Columbia County, following graduation from Milwaukee Medical College. He is a former president of the Manitowoc County Medical Society and a past president of the staff of Holy Family Hospital. His son, *Dr. R. W. Hammond*, is associated with him in his Manitowoc practice.

Members of the Medical Society presented him with a watch.

Montfort Observes Doctor Ketterer Day

June 10 was Dr. E. A. Ketterer Day in Montfort, when more than a thousand persons gathered in the community building to celebrate the doctor's seventieth birthday. Doctor Ketterer, the only physician in the community, has served the health needs of its citizens for forty-five years. Locating in Montfort in 1903, following graduation from Northwestern University Medical School, he remained there except for a period of service as a captain in the Army Medical Corps.

Friends of the doctor presented him with a gold watch in honor of the occasion. Doctors from the vicinity who were present included *Drs. H. M. Walker, William Hamilton*, and *T. A. Hagerup* of Dodgeville; *E. C. Howell*, Fennimore; and *H. D. Ludden* and *E. J. Hohler*, Mineral Point.

Doctors Attend Postgraduate Course in Internal Medicine

Drs. R. C. Cantwell, Shawano, and *G. S. Custer*, Marshfield, were among physicians attending a postgraduate course on "Physiological Basis for Internal Medicine" offered by the American College of Physicians in Chicago early in June. The course was presented at the University of Illinois College of Medicine in Chicago.

Dr. J. H. Wishart Returns to Midelfart Clinic

Dr. John H. Wishart recently returned to his position on the staff of Midelfart Clinic in Eau Claire after two years of research and specialty training in internal medicine and heart disease. He also served on the staff of the Veterans Administration Hospital in Minneapolis and on the faculty of the University of Minnesota Medical School during his absence. The doctor had been associated with the Midelfart Clinic from 1939 to 1941, when he became medical director of the United States Rubber Company, Eau Claire Ordnance Plant. During World War II he was commissioned in the United States Navy.

Dr. J. W. Nellen Establishes Practice in Green Bay

Dr. James W. Nellen, who has practiced in Philadelphia for the past year, recently established a practice in orthopedic surgery at Green Bay. Doctor Nellen completed a residency in orthopedic surgery at the State of Wisconsin General Hospital, follow-

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ing which he served with the United States Navy Medical Corps for four and one-half years. He is certified by the American Board of Orthopedic Surgery.

H. L. Baxter Approved by Navy for Postgraduate Study

Commander Harold L. Baxter, United States Navy Medical Corps, who formerly practiced in Neenah, has been approved by the advisory board of the Bureau of Medicine and Surgery for postgraduate training in neurology at the Jefferson Medical School, Philadelphia. Commander Baxter is a graduate of the University of Colorado School of Medicine. His home is in Waupaca.

W. C. Randolph Opens Manitowoc Office

A former resident in otolaryngology, *Dr. William C. Randolph* recently opened an office in Manitowoc, specializing in treatment of the eye, ear, nose, and throat. Graduating from the University of Wisconsin Medical School in 1944, Doctor Randolph served his internship at the United States Naval Hospital, Long Beach, California. He served in the Navy Medical Corps during World War II.

Dr. L. G. Kindschi Attends Postgraduate Course

Dr. Leslie G. Kindschi, Monroe, attended a one week postgraduate course in neurology presented by the American College of Physicians at Philadelphia late in May. Following the course, he visited the Lahey Clinic in Boston and the Cleveland Clinic in Cleveland.

Dr. J. M. Dodd Receives Life Membership in Legion Group

Dr. J. M. Dodd, Ashland, was awarded a life membership in the Forty et Eight Society of the Ashland American Legion post at its annual meeting on June 10. Doctor Dodd is a former mayor of Ashland.

CORRECTION

On page 624 of the June issue of *The Journal,* Drs. V. F. Marshall, A. W. Montgomery, K. F. Schlaepfer, and J. M. Shramek were listed as being specialists in obstetrics and gynecology. These physicians were certified by the International Board of Surgery as general surgeons.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. L. V. Littig Receives Fellowship in American College of Radiology

L. V. LITTIG

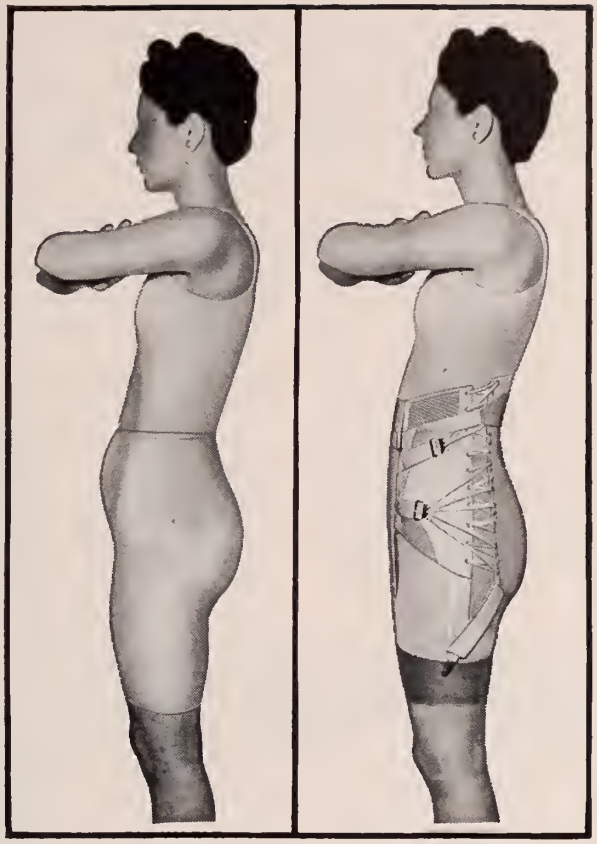
Dr. L. V. Littig, radiologist at Madison General Hospital, on June 20 was granted a fellowship in the American College of Radiology at a convocation at the Sheraton Hotel in Chicago. Doctor Littig, who received his medical degree at the State University of Iowa College of Medicine, joined the staff of Madison General Hospital in 1921.

Dr. J. W. Lawlah Speaks at University of Wisconsin Medical School

Guest speaker for the annual Alumni Day at the University of Wisconsin Medical School was Dr. John W. Lawlah, a former medical student at the university, who is at present professor of radiology at Howard University College of Medicine in Washington, D. C. Doctor Lawlah, formerly dean of medicine at that institution, presented a paper entitled "Thoughts on the Supply, Distribution, and Opportunities for Training of the Negro Physician."

Dr. C. K. Kincaid Named Madison City Health Commissioner

Dr. Charles K. Kincaid, formerly health officer of Will County in Illinois, on July 1 took over his duties as city health commissioner of Madison. Prior to his appointment in Will County, he had served as



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city and county health officer at Eau Claire from 1941 to 1947, with a leave of absence for military service. He served with the Army Medical Corps during World War II, receiving his discharge with the rank of major in January 1946. A graduate of Ohio State University College of Medicine, Columbus, in 1935, the doctor received his M.S.P.H. degree at the University of Michigan Medical School in 1940.

Doctor Kincaid succeeds *Dr. L. H. Fauerbach*, who has been acting commissioner since the death of *Dr. Marshall W. Meyer* in January.

Madison Doctors Attend Surgical Meeting

Drs. John T. F. Gallagher and *Nathaniel G. Rasmussen*, Madison, attended the meeting of the American Association of Surgeons of Trauma in Chicago in June, where Doctor Gallagher presented a paper at the scientific program. The two doctors hold positions in the orthopedic department of Jackson Clinic and Methodist Hospital.

Dr. Hans Reese Named to Official Position

H. H. REESE

Dr. Hans Reese of Madison was elected vice-president of the American Neurological Association at its annual meeting in Atlantic City, New Jersey, in June. Doctor Reese is professor of neuropsychiatry at the University of Wisconsin Medical School. Dr. Stanley Cobb of Boston was named to the presidency of the organization.

SOCIETY PROCEEDING

Dane

Baseball teams from the staffs of four Madison hospitals were organized to provide entertainment for members of the Dane County Medical Society when they gathered for their annual spring outing at Mendota State Hospital on June 10. Physicians from Madison General, Wisconsin General, St. Mary's, and Methodist hospitals participated, with the team from Madison General Hospital winning the championship title. Dinner was served at 6:30.

The public relations committee of the Society met at the Madison Club on May 20 to draw up a report to be sent to the city manager of Madison concerning the need for hospital beds in the city. It was recommended that steps be taken to convert the East Washington Hospital into a hospital for convalescent patients and to erect temporary Quonset type structures on the Madison General Hospital grounds to serve as contagious disease units.

TWELFTH DISTRICT NEWS

Dr. J. G. Taylor Elected State Director of National Tuberculosis Group

Dr. J. Gurney Taylor, Milwaukee, was elected representative director for Wisconsin for the National Tuberculosis Association at the annual conference of the association and its affiliated groups at New York on June 15. Directors at large for Wisconsin, also selected at the convention, are *Dr. O. A. Sander* and Mr. William Ross, both of Milwaukee.

SOCIETY RECORDS

New Members

Frederick I. Bush, West Bend.

Robert L. Gilbert, 1707 Main Street, La Crosse.

John F. Pember, 703 Court Street, Janesville.

John M. Lynch, Monroe Clinic, Monroe.

Miles B. Smith, Veterans Administration, Wood.

Robert L. Bradley, Veterans Administration, Wood.

Carl F. Glienke, 2616 North Eighty-third Street, Wauwatosa.

Walter F. Merginder, Jr., 2320 North Lake Drive, Milwaukee.

David J. Carlson, 2320 North Lake Drive, Milwaukee.

John G. Frisch, 4830 North Berkeley Boulevard, Milwaukee.

Richard K. Chambers, 1022 North Tenth Street, Milwaukee.

Maurice Greenberg, 161 West Wisconsin Avenue, Milwaukee.

Robert H. Bowden, 8700 West Wisconsin Avenue, Wauwatosa.

Russell R. Redlin, 3270 South Forty-fifth Street, West Allis.

Norbert G. Bauch, 1845 North Fourth Street, Milwaukee.

Thomas J. Foley, 709 North Eleventh Street, Milwaukee.

Richard O. Bauman, 425 East Wisconsin Avenue, Milwaukee.

Eugene F. Brandt, Veterans Administration, Wood.

Harold N. Heinz, 408 West Madison Street, Milwaukee.

John T. Hotter, 8844 Watertown Plank Road, Wauwatosa.

Wilfrid L. Seng, 1403 North Aster Street, Milwaukee.

Henry A. Norum, 8700 West Wisconsin Avenue, Wauwatosa.

Robert F. Scheller, 435 East Lincoln Avenue, Milwaukee.

Donald L. Knutson, Veterans Administration, Wood.

George R. Thuerer, 1300 University Avenue, Madison.

Richard P. Embick, 1300 University Avenue, Madison.

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John A. Buesseler, 651 University Avenue, Madison.

Hyman K. Parks, 16 North Carroll Street, Madison.

William B. Hobbins, 2415 Norwood Place, Madison.

Emerson J. Collier, Madison General Hospital, Madison.

John H. Juhl, Wisconsin General Hospital, Madison.

Walter E. Luedtke, Wisconsin General Hospital, Madison.

E. George Nadeau, Jr., 401 Bellin Building, Green Bay.

Changes in Address

Alexander Kremers, Kaukauna, to P. O. Box 431, Waupun.

J. E. Jenson, Eau Claire, to Stillwater, Minnesota.

H. J. Werbel, Milwaukee, to 607 Walworth Avenue, Delavan.

Samuel Klein, Wauwatosa, to 350 North Hickory Street, Joliet, Illinois.

G. K. Kambara, Madison, to 622 O Street. Sacramento, California.

R. F. Swanson, Oxford, to 443 North Lombard Avenue, Oak Park, Illinois.

C. K. Kincaid, Joliet, Illinois, to City Health Commissioner, City of Madison, Madison.

G. J. Hathaway, Superior, to King.

C. A. Hardin, Madison, to University of Kansas Medical Center, Kansas City, Kansas.

L. S. Eagleburger, Stevens Point, to Amherst.

J. J. Purtell, Boston, Massachusetts, to 161 West Wisconsin Avenue, Milwaukee.

W. C. Randolph, Madison, to 819 Hancock Street, Manitowoc.

C. R. Treat, Lake Worth, Florida, to Sharon.

A. C. Yerkovich, Wauwatosa, to 101 Gates Avenue, Lackawanna, New York.

A. J. Bown, Waukesha, to Cook County Hospital, Chicago, Illinois.

J. A. Buesseler, Madison, to Department of Ophthalmology, Hospital of University of Pennsylvania, Philadelphia, Pennsylvania.

N. M. Clausen, Oregon, to 2 West Gorham Street, Madison.

MARRIAGE

Dr. Bernard P. Waldkirch and Miss Louise Marie Lindrud, De Pere, on June 8.

DEATHS

A former president of the State Medical Society of Wisconsin, **Dr. Otho Fiedler**, Sheboygan, died at a Sheboygan hospital on June 22. The doctor, who was 75 years old, served as chief executive of the Society in 1932. He had also served on the State Board of Health for fourteen years, being president of the Board at the time of his retirement.

A native of Wisconsin, Doctor Fiedler was born on March 9, 1873. He was educated at Whitewater State Teachers College, following which he taught in Sheboygan High School for several years. After service in the Spanish–American War, he attended the Wisconsin College of Physicians and Surgeons, now Marquette University School of Medicine, from which he secured his medical degree in 1902. Following graduation, he served as chief of the laboratory service of the Milwaukee Health Department and was a member of the staff of Marquette University School of Medicine for eight years. After two years of postgraduate study in Vienna, Doctor Fiedler established a practice in Sheboygan in 1913. He remained in that city except for a period of service as a lieutenant colonel in the Army Medical Corps during World War I.

In 1921 Doctor Fiedler organized the Sheboygan Clinic, and he was also instrumental in the organization of the Sheboygan Memorial Hospital. He had served as chief of staff of both institutions, and at one time was president of the Sheboygan Clinic. He was active in State Medical Society affairs, serving as chairman of the Committee on Public Policy and representing the state on the Auxiliary Legislative Committee of the American Medical Association at various times. He also was a member of the Special Legislative Committee of the State Medical Society. A charter member and former president of the Northwest Regional Conference, he was also a former trustee of Marquette University School of Medicine. He was a member of the Sheboygan County Medical Society and a fellow of the American College of Surgeons.

Survivors include his wife, two sons, and a daughter.

Following the death of Doctor Fiedler, the Sheboygan County Medical Society adopted the following resolution:

> WHEREAS, the passing of Dr. Otho Fiedler has brought us to reflect on his many accomplishments, and
>
> WHEREAS, our membership has long been indebted to him for his many services in various capacities, to our society, the State Medical Society, and the American Medical Association, and
>
> WHEREAS, we are humbled in our knowledge that forty-six years of medical practice shall be accomplished by but a few of our number, and
>
> WHEREAS, his professional skill marked him as a physician in whom both patients and brethren had great faith,
>
> *Now, therefore, be it resolved* by the Sheboygan County Medical Society that we express our great appreciation for all that Dr. Otho Fiedler has given us, and that we convey our deepest sympathies and condolences to his family in their bereavement.
>
> *Be it further resolved* that the above sentiments be spread upon records of the Sheboygan County Medical Society.
>
> E. T. HOUGEN, M. D.
> *President*
> J. F. KOVACIC, M. D.
> *Vice-President*
> J. F. HILDEBRAND, M. D.
> *Secretary and Treasurer*

Dr. Harry W. Housley, a member of the staff of Mendota State Hospital in Madison, died at a Madison hospital on April 2. He was 62 years old.

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Doctor Housley was born in Lincolnshire, England, on May 8, 1885. He came to the United States at an early age and received his medical education at Milwaukee Medical College, graduating in 1912. He served his internship at Peoples Hospital and Cook County Hospital in Chicago. After thirty years in general practice at Neillsville, the doctor joined the staff of Mendota State Hospital in 1944. He had served as health officer in several townships for twenty-nine years and was coroner of Clark County for many years.

The doctor was a member of the Dane County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and a daughter.

Dr. Henry W. Kleinschmit, 61, an Oshkosh physician, died at his home in that city on May 19.

A native of Winnebago County, the doctor was born on March 5, 1887. He had resided in Oshkosh for sixty years and had practiced there for thirty-three years. He received his medical education at the University of Illinois College of Medicine, graduating in 1914. His internship had been served at St. Joseph's Mercy Hospital in Detroit.

The doctor was a member of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association. He served on the staff of Mercy Hospital in Oshkosh.

Survivors include his wife and a daughter.

Dr. William A. Sickels, one of the first roentgenologists in the United States, died May 19 at his home in South Milwaukee. He was 77 years old.

Born in Monroe, Michigan, in 1870, the doctor received his medical degree from Wayne University College of Medicine, Detroit, in 1896. Following World War I, during which he served with the Army Medical Corps, Doctor Sickels located in South Milwaukee. Prior to the war he had practiced in Milwaukee and East Lake, Michigan.

A member of the Fifty Year Club, Doctor Sickels was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

A daughter and a son survive.

CORRESPONDENCE

An Open Letter to the Physicians of Wisconsin

O' Lord that I may see!

The Wisconsin Medical Journal, April 1948, carried a tear-out advertisement of "The Blood Chemistry Service to Physicians in Wisconsin," a function of the Wisconsin Psychiatric Institute. The location of this ad, facing "Notes on Clinical Pathology," a service of the Wisconsin Society of Pathologists, is purely coincidental. Lest its position and our silence be interpreted as approval, the Wisconsin Society of Pathologists wishes to make certain comments.

The Wisconsin Psychiatric Institute has authority to conduct such tests and examinations as may be necessary to stay the Wisconsin's citizen from becoming a state's charge. Originally this centered around preventive medicine, mainly diagnosis of syphilis by blood and cerebrospinal fluid examinations. The service has subsequently wandered into clinical chemistry; from nonprotein nitrogens and blood sugars for physicians not having laboratory facilities to blood protein, mineral, and enzyme determinations for anyone anywhere which service, according to W. L. Lorenz, "would perhaps prevent mental diseases."

Let us ask ourselves how many cases under this premise have been treated from the standpoint of blood chemistry alterations and have thus been spared mental disease, that is, have not become state charges? Let us have figures if the doubled number of determinations, 1947 and 1943, have doubled the number of cases in which mental disease was prevented, or did the census in the institutions steadily increase during this period. Let us ask, furthermore, does a program under such a premise warrant any support? Certainly if a pathologist and private physician, with interview and examination of the patient, cannot determine the likelihood of the patient's becoming an institutional charge, then no mail order service can.

Should this premise be true even in judgment by finest "micro methods," then it would behoove us as physicians of this state to send to the Wisconsin Psychiatric Institute, for interpretation, our electroencephalograms, electrocardiograms, roentgen ray pictures, and tissues, for who can tell what condition or what patient may at any time become an inmate of a state institution. Truly it would be far better to send the patient, for one can tell more about such problems by seeing the patient than by having blood samples.

My dear fellow physicians, at any time that medical services, free of charge, become available to individuals capable of paying for such services, we have a serious problem in the making. When we speak of indiscriminate free medical service, there can be only one denominator, whatever this be called. As physicians our unanimity of aim is to preserve the traditional manner of the practice of medicine. Injudicious and indiscriminate use of state operated or free services without regard for existing local private facilities is not a step in this direction.

O' Lord that I may see what I do!

Yours for the private practice of medicine,

J. F. Kuzma, M. D.

President, Wisconsin Society of Pathologists

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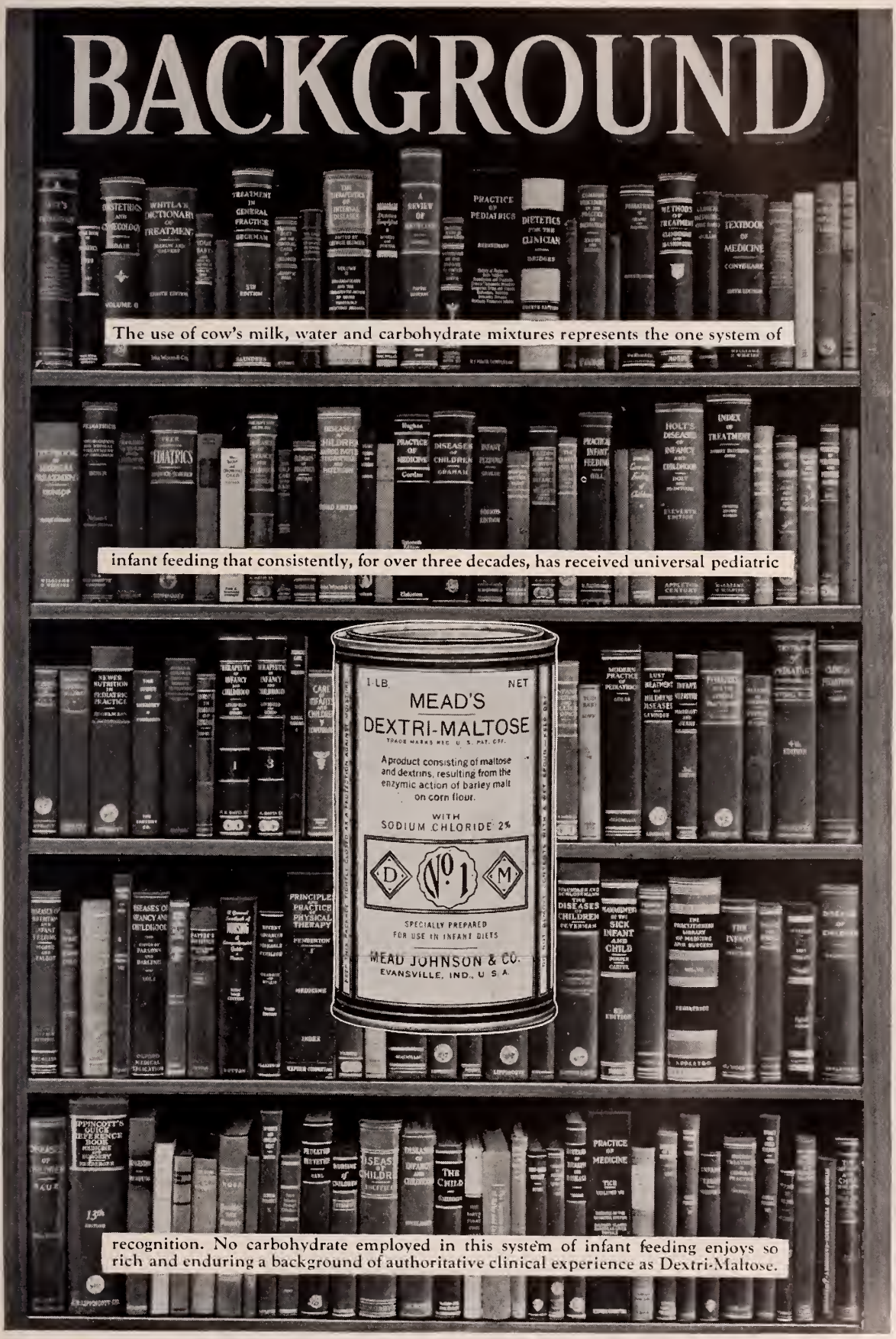
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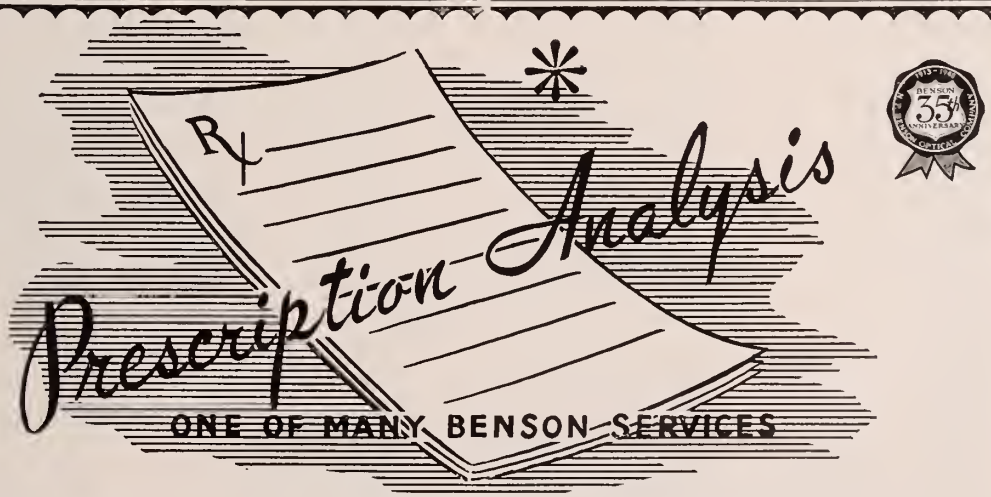

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*BOGERT, L. J.: *Nutrition and Physical Fitness, 4th edition, 1943, Chapter IX, p. 22.*
**A.M.A.: *Handbook of Nutrition, 1943, p. 360.*

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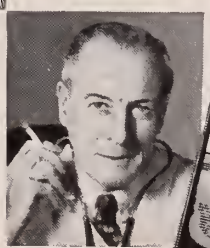

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Psychopathology and Education of the Brain-Injured Child. By Alfred A. Strauss, Psychoeducational consultant, Evanston, Illinois; President, Cove Schools for Brain-Injured Children, Racine, Wisconsin; and Laura E. Lehtinen, Psychoeducational consultant, Evanston, Illinois; Educational director, Cove Schools for Brain-Injured Children, Racine, Wisconsin. Pp. 206, with 46 illustrations. New York: Grune and Stratton, 1947. Price $5.00.

This small volume is packed full of basic sound knowledge long needed to supplement our knowledge of the psychopathology of childhood, particularly the brain-injured child. In the past we have depended on data derived from study of the brain-injured adult. Though there are some definite correlations, the fallacy of comparing the individual whose personality structure and motor patterns were well developed before injury with that of the organism whose nervous system had not yet matured, was only too apparent.

Drawing heavily upon the works of authors who studied brain-injured soldiers of World War I, Strauss and Lehtinen were stimulated to study children physically handicapped, or physically sound who showed intellectual and personality aberrations as a result of injury to the brain substance. They were able to see in the children they studied some of the characteristics of adult brain-injured as described by Goldstein and others. Emotional lability, distractibility, perseveration, and perceptual disturbances characteristic of adult brain-injured were to be found in the child counterpart. The authors devised a series of tests by which they examined children. Normal children, feeble-minded children without organic substrate, and brain-injured children with and without physical handicaps were examined by these special technics. The visuoperceptual, the auditoperceptual and the tactoperceptual areas were examined by ingenious test material involving motor performance. By means of these projection technics, the authors showed that certain disturbances of brain-injured children belong to a characteristic perceptual motor syndrome which can be observed to exist in the visual, tactual, and auditory fields. To explain one aspect of distractibility which has long been observed in those with residuals of brain injury, Strauss and Lehtinen set up visuomotor tests, that definitely pointed to inability to differentiate foreground from background. There was a fluctuation of interest between background and foreground stimuli so that the child was not able to see clearly the central theme or to separate the foremost or primary idea from its confusing background. Similar results were obtained by testing hearing and tactile faculties eliminating the visual apparatus. Perseveration was demonstrated in a number of ways expressed through the same perceptual fields by test material calling for performance. Thinking disorders were demonstrated by exploration of conceptual relationships by means of picture and object assemblies. Brain-injured children showed diffuseness or lack of clarity in thinking by selection of more objects or uncommon choices and fantastic reasons for selections of objects to illustrate action of a picture.

The weakest part of this work is in the efforts of the authors to differentiate behavior disorders of brain-injured children from those of children suffering from encephalitis or schizophrenia or showing the behavior of those with personality structure as categorized by the meaningless term "psychopathic personality." With regard to the latter, all know the snares and pitfalls of this classification. Many of these persons are undoubtedly instances of unappreciated brain injuries, perhaps unrecognized asphyxia at birth; some are schizophrenics who do fit the special categories within that large group; some have had encephalitis or other brain disease. The reviewer doubts if there is enough real distinction in the variable behavior of known encephalitic children to be distinctly diagnostic for this group. All of those who have studied these children have pointed to the similarities in the behavior of the two groups (known brain-injured and known encephalitics). On the basis

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of the disseminated pathology, more or less discrete lesions involving both cell complexes and the white matter, one might anticipate that there would be marked similarity in the objective disturbances of encephalitis, asphyxia at birth and certain types of civilian head injury. In schizophrenia, as developed so well by Lauretta Bender in her observations of 100 schizophrenic children, there occur variable motor patterns, disturbances in thinking and in affective relationship to the environment and overall anxiety secondary to the confusion produced in the child by the schizophrenic process. The authors have used the symptomatology formulated by Bradley to characterize the schizophrenic child. These symptoms are those of the older child whose psychic life is more like that of the adult schizophrenic.

The strength of the work lies in the field of detection of the perceptual disturbances and its implication in the educational treatment of the brain-injured child. It is apparent that children with these perceptual defects cannot be taught as they are at present in the public schools. Failure to be understood and to achieve leads secondarily to anxiety and behavior disturbances. Strauss and Lehtinen, recognizing these handicaps, have set up learning technics for meeting these special handicaps. The physical aspects of the classroom are adjusted to the individual problem. The distractibility of the brain-injured child is met in special ways that might well be adapted by the public school where the handicapped are educated.

This work has real scientific merit. It has succeeded in developing objective means of detecting specific defects in organic functioning of the brain leading to failure of normal intellectual development and secondarily to disturbance in patterned behavior and personality structure. It stands beside Ward Halstead's work on the adult brain-injured (The Brain and Intelligence—U. of Chicago Press 1947) which proves that there are facets of "biologic intelligence" not revealed in the intelligence quotient and over-all appraisal of intelligence by the usual intelligence tests, though the discriminating psychologist can get leads by means of them in the direction of specific defects calling attention to organic disorder. The second part of the book should be thoroughly read by all who are engaged in the education of the handicapped children especially that poorly understood group of cerebral palsied.

This is an especially deserving piece of work. The authors are to be highly commended.—M. G. M.

Physician's Handbook. By John Warkentin, Ph. D., M. D.; and Jack D. Lange, M. S., M. D. Fourth edition. Pp. 282. Paper. Chicago: University Medical Publishers, 1946. Price: $1.50.

This is a well arranged and useful handbook for quick and ready reference in connection with the current diagnostic procedures as they apply to medical practice. The section on bacteriology has been completely revised and a section on mycology has been added including diagrams of yeasts and fungi.

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The text includes such subjects, chosen at random, as examination of the comatose patient, parasites, psychiatric history and examinations, vitamins, diabetes, duodenal drainage, blood chemistry normals, Rh factor, and serodiagnosis. A very complete index is included, and the handbook is conveniently divided into two parts—the laboratory diagnosis, and clinical procedures and facts.

This little handbook is of convenient pocket size, paper-covered, and it contains up-to-date information of value to the intern or resident, as well as the practicing clinician. There is only one criticism and that is the size of the print, which makes prolonged reading somewhat difficult.—L. R. C.

Pharmacology, Therapeutics and Prescription Writing; for Students and Practitioners. By Walter Arthur Bastedo, Ph. G., Ph. M. (Hon.), M. D., Sc. D. (Hon.), F. A. C. P., Consulting Physician, St. Luke's Hospital, New York; St. Vincent's Hospital, Staten Island, and the Staten Island Hospital; President, U. S. P. Convention 1930–40; Member Revision Committee, U. S. P. Formerly Curator of the New York Botanical Garden; Attending Physician, City Hospital, New York; Instructor in Pharmacology, Cornell University; Associate in Pharmacology and Therapeutics and Assistant Clinical Professor of Medicine, Columbia University. Fifth Edition. Pp. 840, with 82 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price: $8.50.

The current revision of this standard medical work brings it abreast of the generally accepted methods of medical treatment. Advances in therapeutics have been so great that it has been rewritten completely and has been brought into conformity with the U. S. P. XIII.

In addition to the material previously included, new drugs which have been added during the ten years' lapse since the fourth edition include the amino acids, blood fractions, coagulants and anticoagulants, heparin, dicumarol, curare, snake venoms, analeptics, antihistaminic drugs, folic acid, rutin, thiouracil and propylthiouracil, the antibiotics penicillin and streptomycin, new analgesics such as demerol and metopon, the cardiac glycosides, antimalarials, the mercurial diuretics, and BAL as used in the treatment of poisoning by arsenic, gold, and other heavy metals.

The material in general is brief and rather well presented, but certain errors and inaccuracies, always inherent in such an extensive work, are evident. Thus, on page 56 the formula for choline is glaringly inaccurate. The information regarding curare and *d*-tubocurarine is confusing, incorrect as to conversion ratios, and definitely misleading. To those who have employed it clinically in even a few instances the inadequacy and complete nondependability of neostigmine as an antidote is well recognized. While in general well prepared, the illustrations as a whole are disappointing due to the poor quality of paper on which they appear. This makes some of the one and two page illustrations almost a waste of space (cf. P240–241).

The virtues of the book may in part outweigh its shortcomings.—O. S. O.

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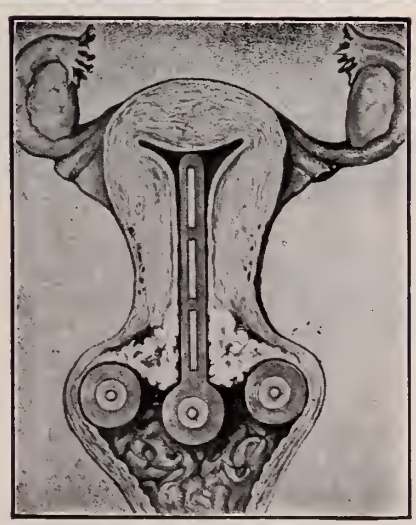

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TRADE NEWS

Dr. C. H. Kalb to Carry on Research For Rexair

Dr. Clifford H. Kalb, Milwaukee, has been assigned to a year-long project of research on the effects of house dust and the effectiveness of a churning water bath in trapping such dust and thereby reducing its incidence in the average household. His assignment will include the directorship of a newly formed medical research bureau of the Rexair Division of Martin–Parry Corporation.

An important aspect of this research will be a study of the pollen and mold spore components of house dust, including their nature, circulation pattern, and means of elimination. Particular attention will be paid to possible value of settling dust in water as a means of controlling it in the home.

Cultural characteristics of mold forms and their relation to clinical allergies are of special interest to Doctor Kalb, a former Fellow in the Allergy Unit, Graduate School of Medicine, University of Illinois. Doctor Kalb obtained his medical training at Marquette University School of Medicine and interned at Milwaukee Hospital. He served with the Army in the Southwest Pacific, and, while on duty as a medical officer in the tropics, became interested in molds and their relation to respiratory diseases. Doctor Kalb is medical director of Milwaukee State Teachers College, and clinical assistant and lecturer in immuno-mycology in the allergy unit of the Graduate School of Medicine, University of Illinois. He is a Fellow of the American Medical Association and is affiliated with the American Academy of Allergy, the American College of Allergists, and the Chicago Society of Allergy, and is head of the research staff of the Medical Research Institute.

Included in Doctor Kalb's comprehensive research covering the subject of Rexair in all its medical aspects will be a study of the efficiency of Rexair in removing dust from the air of representative rooms, a study of the relative efficiency of Rexair and conventional methods of house-cleaning in removing dust from the air, and the efficiency of Rexair in eliminating pollen from the air in the late summer months. An investigation of glycol vaporization in connection with Rexair will also be included. The results of the findings of Doctor Kalb and his associates will be released to scientific publications from time to time, and will be available to practicing allergists and general practitioners in bulletin form.

Although the research program will be carried on in several centers, the over-all direction will be from Doctor Kalb in Milwaukee, working in close conjunction with the Rexair home office in Toledo, Ohio. Doctor Kalb will also continue his private practice in clinical allergy in Milwaukee.

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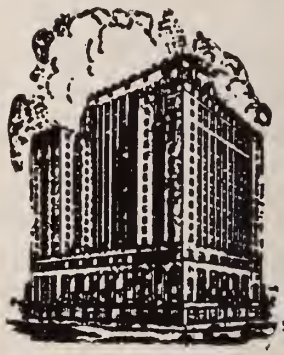

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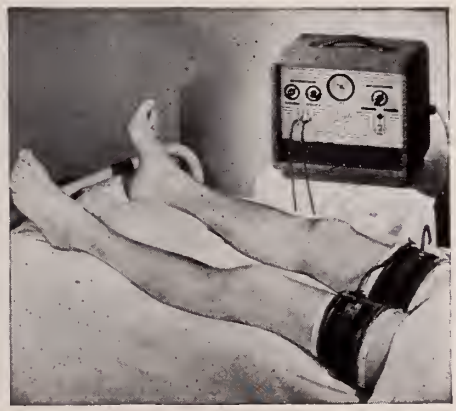

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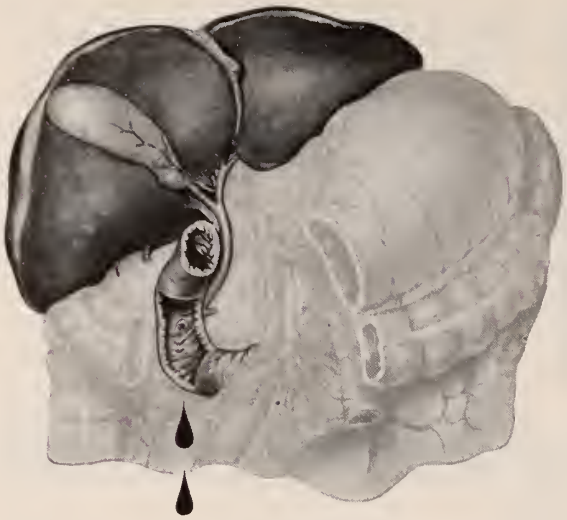

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	711
American Meat Institute	660
Ar-Ex Cosmetics, Inc.	728
Ames Company, Inc.	740
Audiphone Utilities	733
Ayerst, McKenna & Harrison, Ltd.	670
Barlow–Maney Laboratories	667
Barr X-Ray Company	734
Bellevue Place	736
Benson Optical Company	725
Bergmann Prescription Center	731
Bilhuber–Knoll Corporation	657
Borden Company	727
Camel Cigarettes	729
Camp, S. H. and Company	715
Central Drug	728
Ciba	659
Continental Casualty Company	665
Cook County Graduate School of Medicine	735
Doerflingers	736
Downs X-Ray Company	713
Eaton	661
Endocrine Laboratories	735
First Central Dispensary	731
Hotel Schroeder	736
House of Bidwell	734
Hurley X-Ray Company	739
Ivanhoe Treatment, Inc.	737
Jensen Brothers Prescriptions	728
Kennedy–Mansfield	738
Lilly, Eli and Company	facing page 671
Lov-é Brassieres	658
Luzier's Cosmetics, Inc.	721
M & R Dietetic Laboratories	719
Mallatt Pharmacy	731
Massachusetts Protective Association	733
Mather Pharmacy	728
Mayer Drug	728
Mead Johnson and Company	723, 742
Medical Protective Company	668
Milwaukee Optical Company	731
Milwaukee Sanitarium	744
New World Life Insurance Company	733
New York Polyclinic	734
Orthopedic Appliance Company	733
Page Milk Company	662
Parke Davis and Company	654, 655
Philip Morris	669
Physicians Casualty Association	737
Physicians Radium Association	739
Pogue, Mary E. School	739
Prescription Pharmacy	731
Radium Emanation Corporation	735
Radium Service Corporation	737
Rennebohms	731
Rentschlers	738
Rexair	666
Riggs Optical Company	656
Rogers Memorial Sanitarium	744
Sacred Heart Sanitarium	725
St. Croixdale Sanitarium	657
Schering	717
Schlintz Bros. Drug Store	728
Searle, G. D. and Company	709
Shorewood Hospital Sanitarium	713
Summit Hospital Sanitarium	731
Upjohn	663
Winthrop–Stearns, Inc.	743
Wyeth	664

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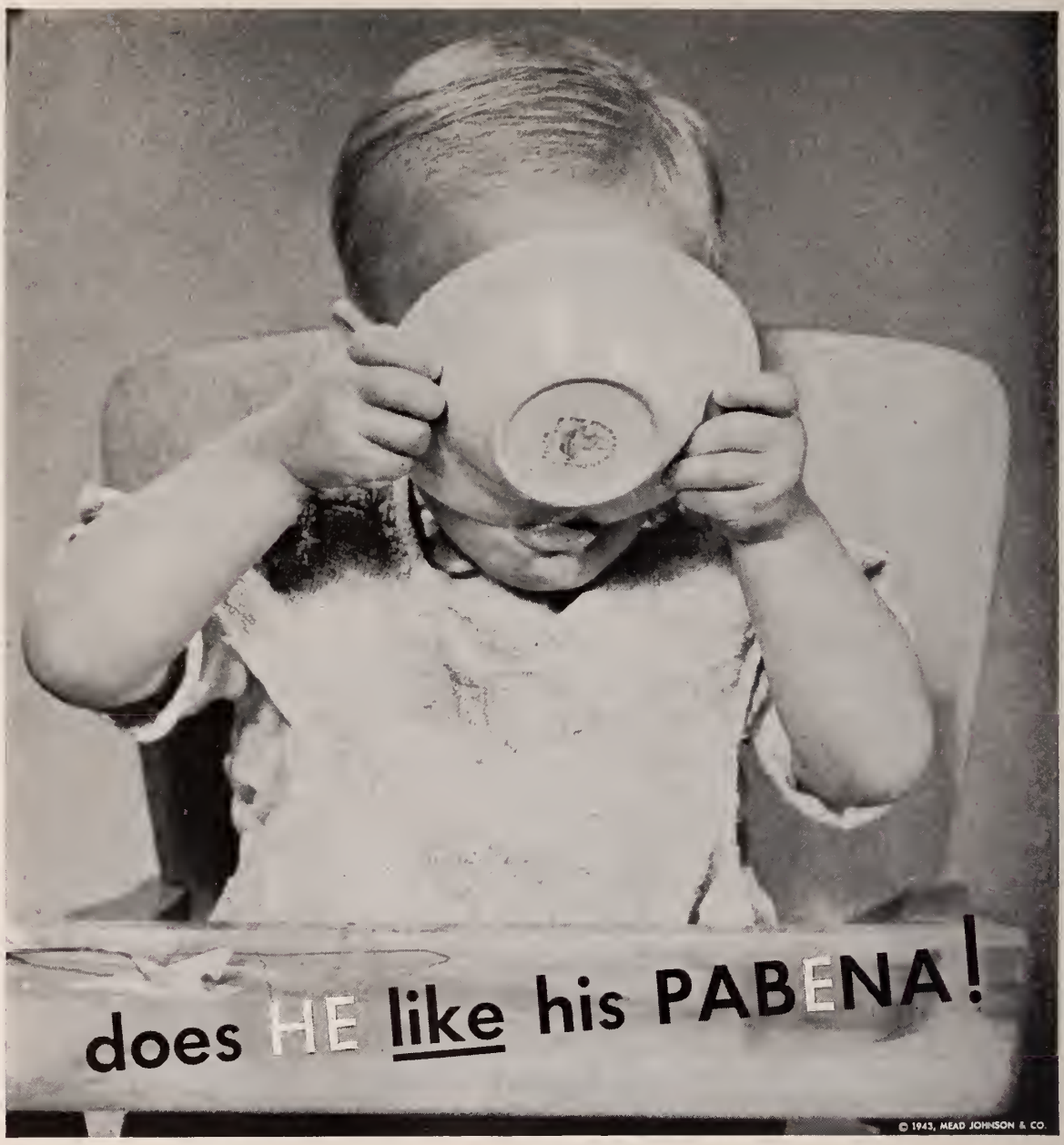

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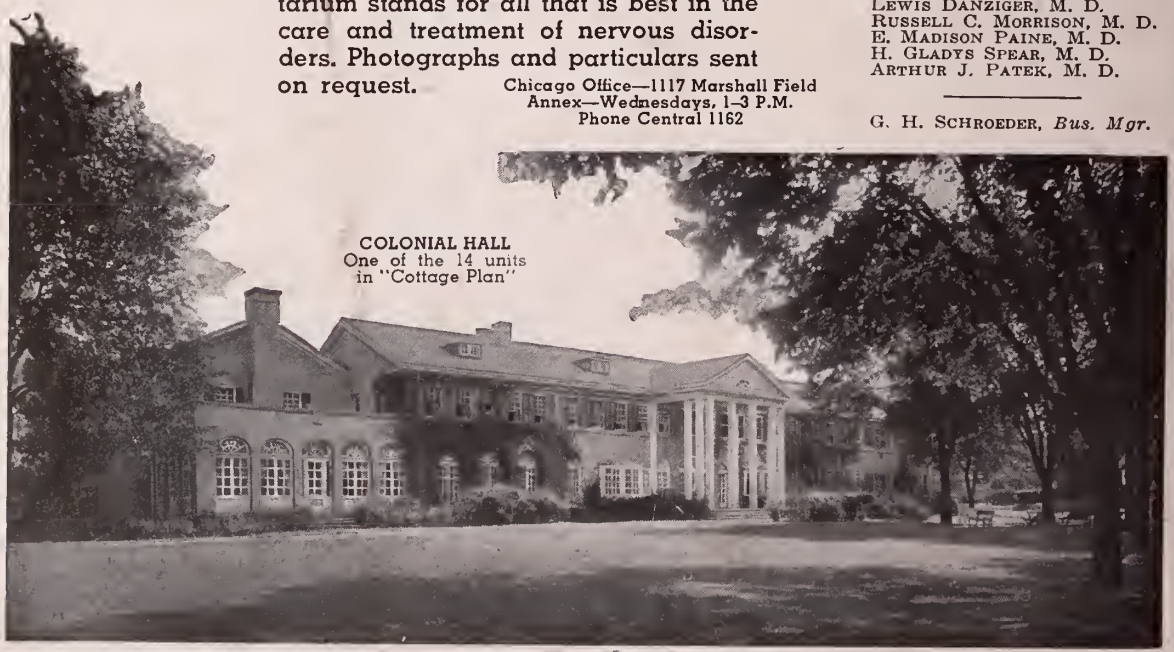

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TABLE OF CONTENTS, PAGE 748

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

Reconstruction of a New Thumb by Tubular Pedicle and Bone Cartilage Graft, by Creighton A. Hardin, M. D., Kansas City, Kansas ---- 763

Stevens–Johnson Syndrome; Report of a Case With Two Major and Four Minor Recurrences, by Samuel W. Rosenberg, M. D., Milwaukee ---- 766

The Treatment of Infantile Paralysis During the Acute Stage, by Philip Lewin, M. D., F. A. C. S., Chicago ---- 769

Headaches and Head and Face Pains, by W. J. Frawley, Appleton ---- 773

Acute Obstructive Cholecystitis, by Paul C. Kiernan, M. D., Washington, D. C. ---- 776

Comments on Treatment ---- 780

As It Looks to Your State Board of Health ---- 781

Notes on Clinical Pathology ---- 783

EDITORIAL

Annual Meeting ---- 788

MISCELLANY

Page

The President's Page ---- 784

As It Looks from the Wisconsin State Chamber of Commerce ---- 786

Cancer Teaching Clinic ---- 787

Annual Meeting

Preliminary Program ---- 789

Scientific Exhibits ---- 803

House of Delegates ---- 806

The Annual Dinner ---- 807

Society Proceedings ---- 808

News Items and Personals ---- 810

And About the Third and Twelfth Districts ---- 814

Society Records ---- 814

Marriages ---- 816

Deaths ---- 816

The Woman's Auxiliary ---- 818

The Journal Bookshelf ---- 820

Correspondence ---- 824

Coming Events ---- 826

Index to Advertisers ---- 830

Physicians' Exchange ---- 832

List of Executive Officers of County Medical Societies ---- 833

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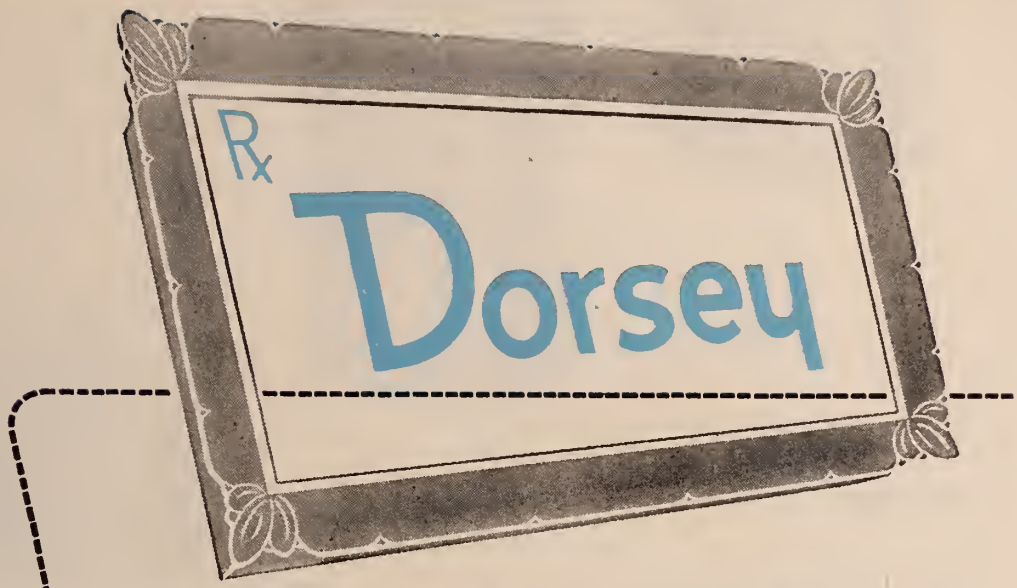

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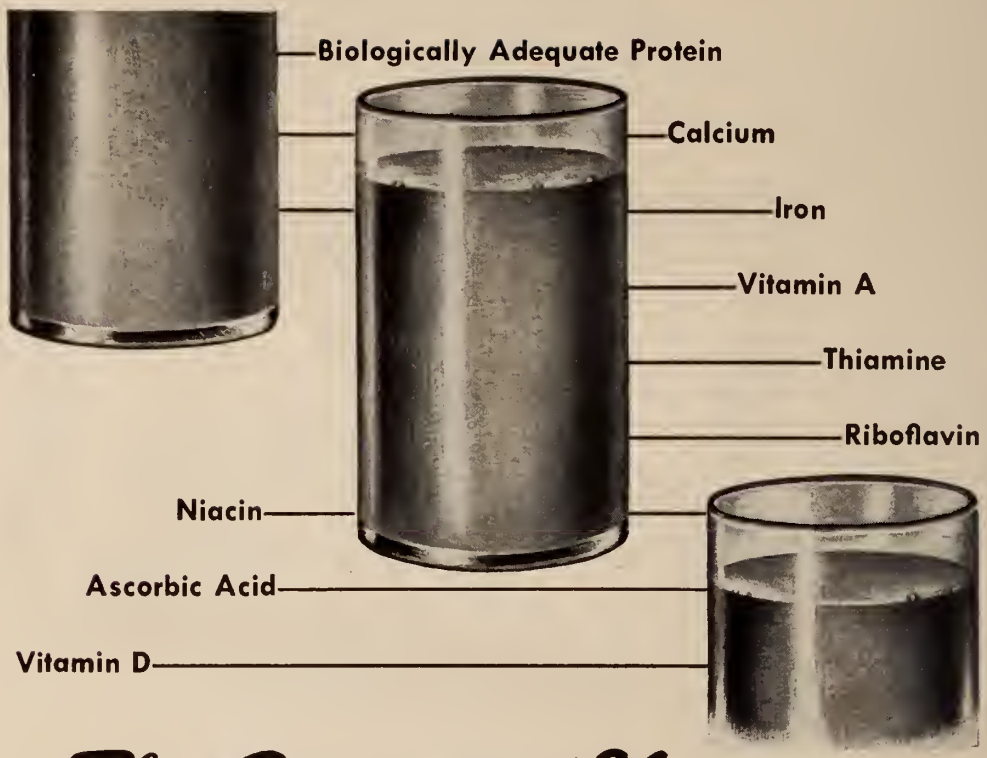

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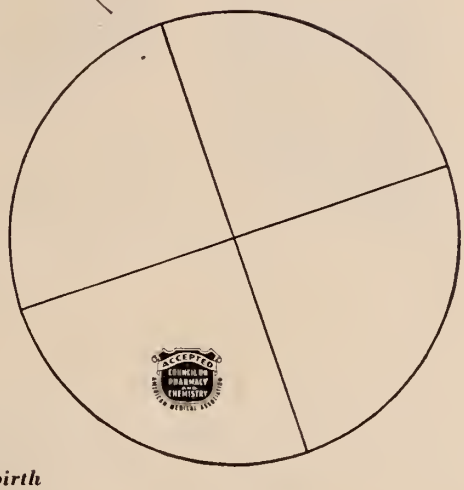

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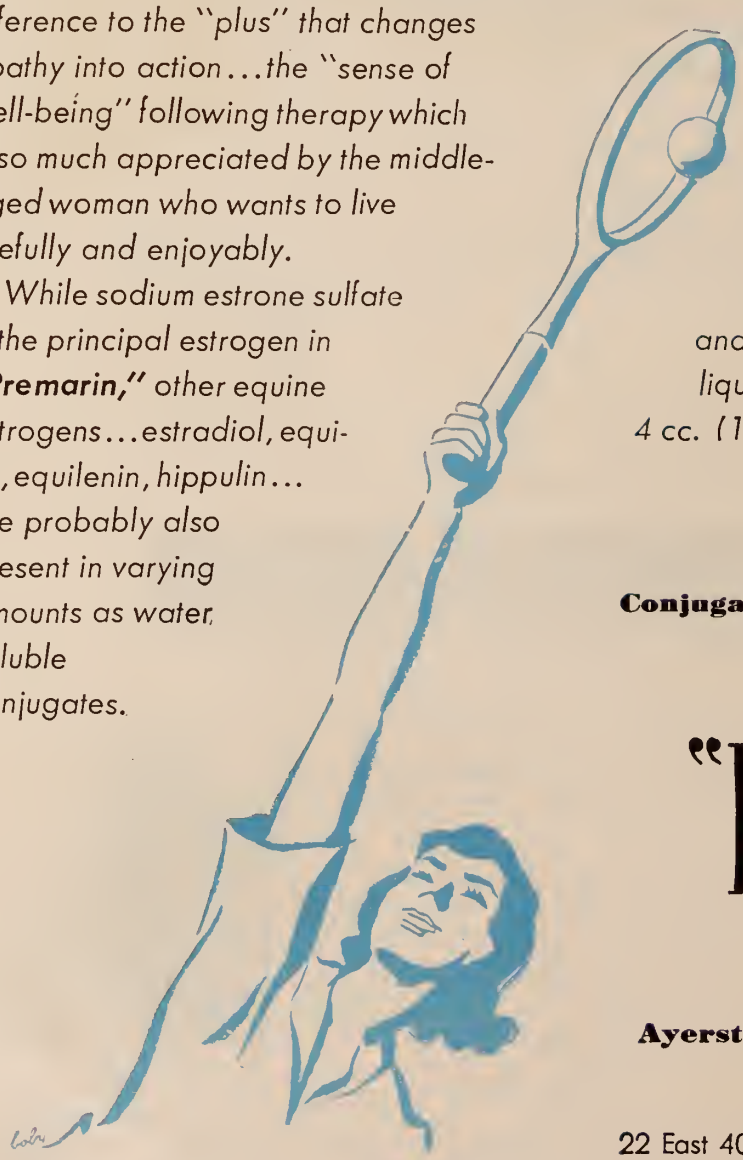

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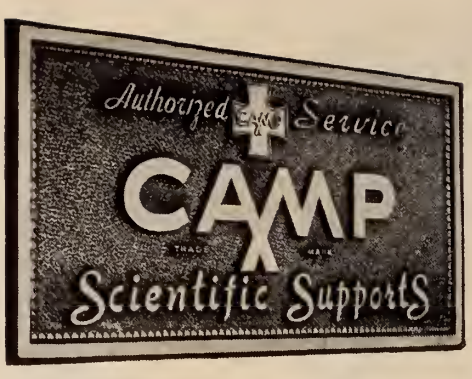

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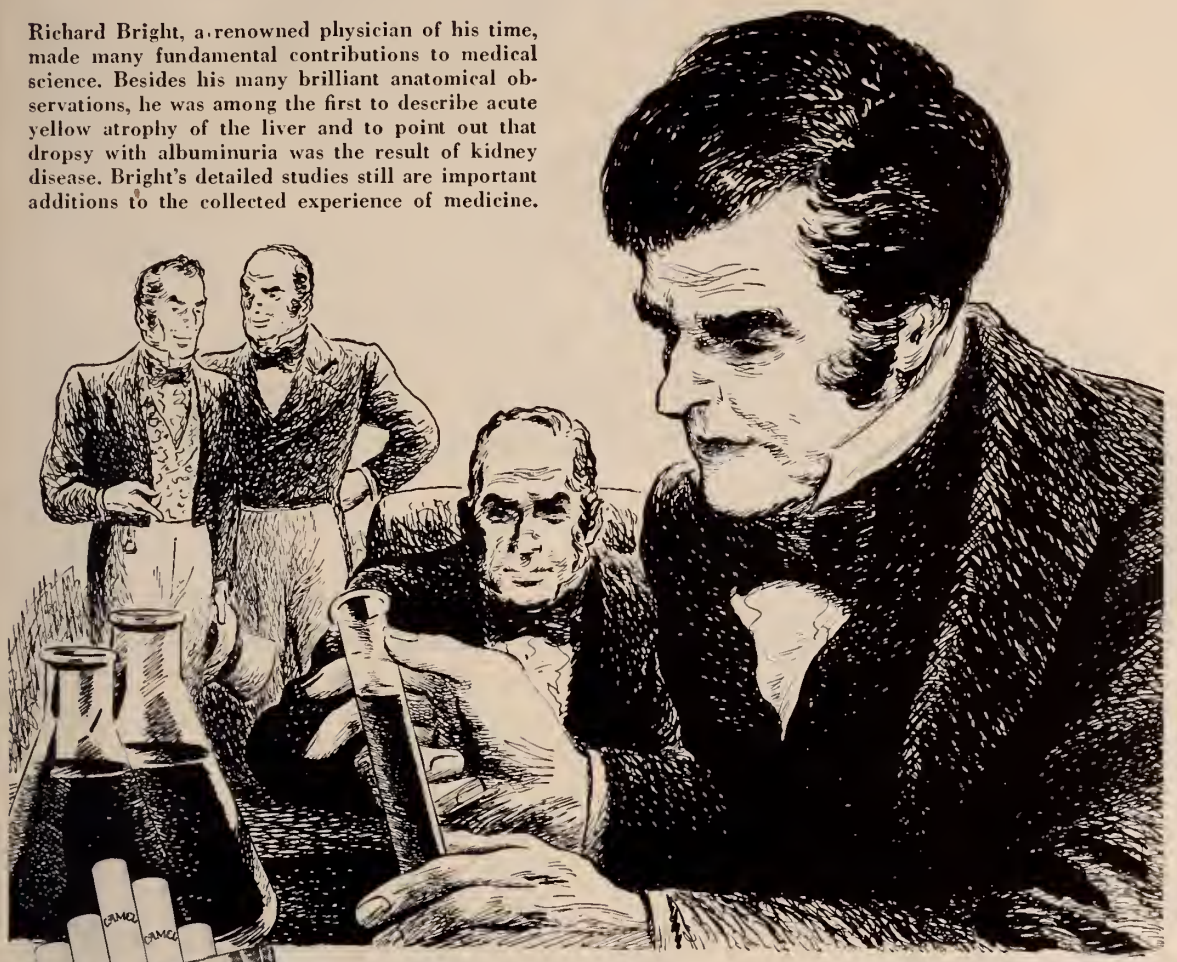

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Reconstruction of a New Thumb by Tubular Pedicle and Bone Cartilage Graft

By CREIGHTON A. HARDIN, M. D.

Kansas City, Kansas

C. A. HARDIN

A graduate of the University of Wisconsin Medical School in 1943, Doctor Hardin interned at the United States Marine Hospital in 1943. After a surgical residency at Mansfield General Hospital in Mansfield, Ohio, he served with the Army Medical Corps. At present he is a plastic surgical resident at the University of Kansas School of Medicine.

A 35 YEAR old white male was admitted to the hospital complaining of the loss of his right thumb. Traumatic loss had occurred three years previously. A small, viable, well healed stump was present (fig. 1). Abductor and adductor muscles were powerful and capable of a wide range of motion. X-ray of the hand showed the proximal head of the first metacarpal present (fig. 2).

Fig. 1.—Traumatic loss of right thumb, showing viable stump.

"A hand without a thumb is so crippled that when possible some equivalent should be furnished."[1]

A surgical reconstructive procedure was then started, to fashion a rigid thumb in a position of good opposition by means of a tubular pedicle and bone cartilage graft. The procedure was facilitated by the presence of the proximal head of the metacarpal for fixation of a graft and the intact muscle attachments at the base of the thumb, which would furnish movements. A pedicle graft was raised on the right abdominal wall in the manner described by Bunnell.[2] Longitudinal oblique incisions were made parallel to the skin creases. Length of the tube was about 6 inches long and 3½ inches in diameter (fig. 3).

Fig. 2.—X-ray of proximal head of the first metacarpal, to which arthrodesis of graft was performed.

The skin was undermined widely in a cleavage plane between the deep and superficial fasciae. At each end of the lower short oblique incision, a short diagonal incision was made running downward and toward the other for 1½ inches, making a point of skin at each end. Complete hemostasis was obtained by clamping and ligating all bleeders.

Each of the pointed flaps was sutured to the end of the upper incision of the pedicle. Excessive fat was trimmed from the pedicle tube and the edges closed with 4–0 silk interrupted sutures. In this

Fig. 3.—Raised tubular pedicle graft three weeks old.

manner the suture line of the pedicle did not appose the suture line of the abdominal wall incision.

The abdominal incision was closed with no. 30 steel wire used as retention sutures. The intervening spaces of the incision were closed with 3–0 vertical mattress sutures. A rubber dam drain was placed through a stab wound at each corner of the pedicle to take care of possible drainage resulting from the extensive undermining.

The newly fashioned pedicle graft was separated from the abdominal wall by many layers of dry gauze. Occlusive dressing was applied and sealed with adhesive tape.

The patient had an uneventful postoperative course and was placed on prophylactic penicillin for five days. At the end of a week the pedicle was examined and found to be viable, and no necrotic areas were present. Ten days postoperatively the skin sutures of the pedicle were removed and the viability of the graft was good. Retention sutures of the abdominal incision were removed two weeks from the time of operation. An additional week was allowed to elapse before further procedures were done. The graft was loose and had good vascular tone, and sensation could be elicited in the raised pedicle.

The usual procedure as outlined in the literature is to attach the pedicle to the hand, allow several weeks to elapse, sever, and leave a liberal blind end of pedicle. After the new thumb has viability, the attached pedicle is incised along the scar of closure and the bone graft is inserted into the metacarpal or whatever bony structure remains to work with.[3]

A somewhat different procedure was done in this case. The stump of the right thumb was opened with a dorsal triangular incision, leaving the normal palmar contour present at the base of the first metacarpal. The proximal fragment of metacarpal was cleaned of scar tissue and hollowed out by graduated drills to receive the bone graft. The drilling was done at a forward angle to give the proper position for opposition of the newly fashioned thumb.

An oblique incision was made over the eleventh rib, and a portion of rib and curved costal cartilage was removed. The incision was closed in layers. The bony portion of the rib was shaped by filing to fit into the hollowed socket in the head of the first metacarpal. Fixation was accomplished by interrupted no. 36 steel sutures between the periosteum of the metacarpal and that of the graft.

The utilization of bone and cartilage was decided upon to give the newly fashioned thumb an attitude of partial flexion and therefore enhance its use in opposition (fig. 4).

The lateral portion of the pedicle was now detached, and the resulting skin defect in the abdomen was closed by undermining and suture. The free end of the pedicle was hollowed out to receive the graft by dissection with long curved scissors. The hollowed pedicle graft was slipped over the affixed cartilage and bony graft. Subcutaneous sutures of

Fig. 4.—Graphic illustration showing the method of insertion of the bone cartilage graft.

no. 60 cotton were used to approximate the pedicle to the base of the thumb and eliminate dead space. The skin edge of the pedicle was sutured to the skin at the base of the thumb. The medial portion of the pedicle remained attached to the abdominal wall for blood supply. Boric acid dressings were applied to new incisions and adhesive strapping was applied so that arm and hand could not shift and place tension on the pedicle. A postoperative course of penicillin was given for five days.

The pedicle graft attached to the thumb was inspected every other day to note the viability and blood supply. Skin sutures were removed in ten days, and healing had occurred between the pedicle and the hand (fig. 5). Another week was allowed before the pedicle was detached medially. The distal

Fig. 5.—Tubular pedicle graft attached to hand, with cartilage bone graft in place.

Fig. 6.—Thumb detached from abdomen (ventral view).

Fig. 7.—Dorsal view of detached reconstructed thumb three weeks after attachment of pedicle to hand.

end of the newly fashioned thumb was closed by means of a fish-mouth incision. Complete healing of thumb had taken place three weeks after the attachment of the pedicle to the hand (figs. 6 and 7).

An aluminum metal splint was made for the thumb to maintain a normal attitude of extension. The patient was instructed not to injure or use the new thumb excessively, as a reconstructed prosthesis of this type is very prone to develop trophic ulcers.

Fig. 8.—Side view of reconstructed thumb six weeks following severance of pedicle from abdomen.

A useful surgical constructed prosthesis for opposition was made. The patient is able to touch the midportion of the little finger and has now an aid in the finer movements and uses of a normal hand. Sensation is gradually returning to the new thumb. Rotation, abduction, and adduction are also present in a useful range of motion.

Summary

1. Reconstruction of a new thumb by tubular pedicle and bone cartilage graft is presented.

2. A modification from the routine method of inserting bony and cartilaginous graft is outlined.

3. The patient has a useful extremity with a thumb for opposition, which is one of the most important functions of the hand.

4. Evaluation of sensation, viability, and motion has been observed over a period of seven months.

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3. Armstrong, J. R.: Bone-Grafting in the Treatment of Fracture, Baltimore, The Williams and Wilkins Company, 1945, chapter 13.

BOARD OF EXAMINERS IN THE BASIC SCIENCES ANNOUNCES EXAMINATION DATES

The next examination in the Basic Sciences will be held on September 25 at the Assembly Chamber, State Capitol, Madison, from 8 a. m. to 5 p. m., according to an announcement from the State Board of Examiners in the Basic Sciences. The examination following this will be held on December 4, 1948 at the Plankinton House, Milwaukee, from 8 a. m. to 5 p. m.

Stevens-Johnson Syndrome*

Report of a Case with Two Major and Four Minor Recurrences

By SAMUEL W. ROSENBERG, M. D.
Milwaukee

S. W. ROSENBERG

A graduate of the University of Illinois College of Medicine in 1935, Doctor Rosenberg has been in the private practice of pediatrics in Milwaukee since 1939. He completed his internship and a residency in pediatrics at Cook County Hospital and later took postgraduate courses at Children's Memorial Hospital, Chicago, and Harvard Medical School. During World War II he served for four years in the Army Medical Corps.

THIS disease entity has variously been called eruptive fever with stomatitis and ophthalmia, erythema exudativum multiforme of Hebra, erythema or herpes iris conjunctivae, ectodermosis erosiva pluriorificialis, and erythema multiforme bullosum with stomatitis and conjunctivitis.

The syndrome derives its name from a report of 2 cases by Stevens and Johnson[1] in 1922. The first to describe this entity, however, was Hebra in 1866. Since then, some thirty reports have appeared in the literature. Most recently Soll[3] has reported a series of 20 cases and Wright[4] *et al.*, a series of 9 cases. Klauder[2] in 1937 subdivided the disease into several clinical varieties, mainly, the Hebra type, involving the skin primarily; the type called ectodermosis pluriorificialis erosiva, first described by Fleissinger and Rendu in 1917; and, finally, the Stevens—Johnson type.

The clinical course is characterized by an acute, systemic, febrile condition running a self-limited course of a few days to several weeks and involving, to varying degrees, the respiratory tract, skin, and mucous membranes. The onset occurs usually with pharyngitis and fever, followed after a few days by severe membranous stomatitis and conjunctivitis. The oral lining is usually edematous and covered with numerous vesicles, which soon rupture. This is followed by the formation of a thick membranous exudate, which then sloughs off. The conjunctivitis may vary from a marked conjunctival injection to a purulent conjunctivitis which may lead to corneal scarring, perforation of the cornea with panophthalmitis, and total blindness. A maculopapular or vesicular eruption, varying in severity in individual cases, may be present beginning three to seven days following the onset of the stomatitis. Leukopenia was mentioned by Stevens–Johnson as being a prerequisite for diagnosis, but, since, this theory has been refuted by Ginandes.[5] Soll, in his series of 20 cases, found no leukopenia, and in 10 a leukocytosis, ranging from 12,000 to 24,000 cells. There are no characteristic laboratory findings. No etiologic agent has been isolated, although a virus is suspected. No transmissible agent was recovered by Edgar and Syverton[6] or by Soll following animal and chick egg inoculation with vesicular fluid and saliva.

The differential diagnosis offers no special problem after a number of fairly typical cases have been seen, especially if one keeps in mind that the disease primarily involves squamous and modified squamous epithelium producing inflammatory changes resulting in erythema, followed by exudation of fluid and ending in vesicles, bullae, and pseudomembranes. Secondary is the involvement of the skin in an erythematous maculopapular and finally bullous eruption. The most important conditions to be ruled out in the differential diagnosis are (1) foot and mouth disease, (2) Vincent's angina, (3) drug eruptions, and (4) pemphigus.

Complications are limited almost entirely to the eyes. These consist of corneal scarring and panophthalmitis with either partial or total blindness.

The prognosis is excellent as regards life, only 4 fatal cases having been reported in the world's literature.

Treatment of any kind has had no effect on the general course of the disease. However, some advances have been made of late in the treatment of the only serious complication, namely, the purulent conjunctivitis. Wright *et al.* treated 9 patients with Stevens–Johnson syndrome. Five patients were treated with sulfonamide drugs and 4 patients with penicillin, either systemically or topically, or both. Complete recovery without sequelae occurred in all but 1 case. In this case, mild conjunctivitis developed with slight symblepharon, but no corneal involvement.

One must not be too enthusiastic about the above results, since recovery without eye complications is not uncommon, and 6 of the 9 patients reported above experienced at least one previous attack without permanent ocular damage. Goldfarb[7] treated a 9 year old boy with sulfadiazine and penicillin locally and parenterally, with decided improvement, which seemed to be related in dramatic time sequence to the use of penicillin, especially locally. Goldfarb further found that in a tabulation of 21

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cases of erythema multiforme bullosum with mucous membrane lesions of varying severity, only 5 patients received adequate doses of sulfonamide or other antibacterial agents. In the 7 most severe cases of the remaining 16, in which there was either purulent or membranous conjunctivitis, the patients were left with total or partial blindness. In view of this he suggested that some form of sulfonamide and/or penicillin be used to avoid eye complications.

Report of Case

J. H., a white male, was first seen in August 1939, when 7 years of age. His complaint was "sore mouth." He had been perfectly well until three days previously, when a temperature up to 103 F. developed, accompanied by alternating hot and cold spells but no definite chills.

The past history had two items of significance. When 2 years of age he had had chicken pox, following exposure to an older brother who had the disease. When 5 years of age he had had an attack of sore mouth, which was diagnosed as trench mouth, followed by inflamed eyes and later by a skin eruption which was diagnosed as chicken pox. He had then been perfectly well until the present illness. There was no history of a similar condition in any other member of the family.

Physical Examination.—The patient was a well nourished 7 year old, alert but acutely ill boy with a temperature of 103 F. The conjunctiva was diffusely colored a salmon red. The lips appeared swollen, and tiny vesicles were seen along the inner surface of the vermilion borders. The mucous membrane covering the hard and soft palates was of the same coloring as the conjunctiva. The vesicles were also present over the buccal mucosa, palate, and lips. The vesicles were transparent and contained a colorless fluid, but gave the impression of having a rather thick shell. The skin was normal. Heart and lungs were normal. The abdomen was soft. The spleen and liver were not enlarged. No enlarged cervical lymph nodes were present. The condition was thought to be Vincent's angina in an early stage, but smears taken of the lesions were negative for Spirochaeta and fusiform bacilli. The patient was treated with sodium perborate and hydrogen peroxide mouth wash and 2 per cent gentian violet topically. The following two days the condition became considerably worse. New vesicles appeared and the older ones ruptured. The ruptured lesions coalesced to form a diffuse pseudomembrane which covered the lips, buccal mucosa, both surfaces of the tongue, palate, uvula, and pharynx. Swallowing became very painful and difficult. At the same time rhinitis and bronchitis presented themselves, with a good deal of nasal drainage and coughing. A smear of the mouth lesions was repeated, but was again negative for Spirochaeta and fusiform bacilli. The white blood cell count was 8,200. In spite of the lack of a demonstrable organism, the patient was given Neoarsphenamine topically and intravenously. No appreciable improvement was noted. On the sixth day following onset of fever, and three days following onset of the sore thoart, a number of bullous lesions, ranging in size from ⅛ to ¾ of an inch, were noted on the arms and legs. New lesions appeared on checks, penis, and urethral meatus. The lesions resembled those seen in chicken pox, but were atypical in distribution, since they were mainly on the extremities and none on the chest, back, or scalp. The bulla ruptured, became crusted, and dried up, leaving some discoloration behind.

The conjunctivitis increased in degree, but never became purulent. The child continued to be toxic for about one week, at the end of which time the pseudomembrane began pealing off. The temperature became lower, and the general condition improved considerably. The improvement continued, and in two weeks from onset all signs of the disease had disappeared, save for some increase in pigmentation at the sites of the bulla.

He was then well until June 1942, at the age of 10, when a temperature and sore throat developed and he proceeded to undergo a course identical with that described above. The skin lesions were seen by a dermatologist, who made a diagnosis of "erythema multiforme of the recurrent bullous ulcerative type." His white cell counts on two occasions during the illness were 9,600 and 6,600. He was treated with sulfanilamide, hydrogen peroxide mouth washes, vitamin C, thiamine chloride, Fowler's solution, and, finally, salicylates. His temperature remained at 103 F., for three days, gradually subsided by lysis, and was normal on the seventh day. Again he was completely well by the end of the second week. The conjunctivitis never went beyond the stage of severe injection.

He remained well until March 1943, when the prodromal symptoms described previously developed, followed by mild conjunctivitis and vesicular stomatitis. He was treated with Fowler's solution, gentian violet topically, and mouth washes. The attack subsided without skin manifestations in six days. No laboratory work was done.

His next recurrence came at age of 13, in May 1945, and was similar to the preceding attack, and again was quite mild. He was treated with Neoprontosil, which was immediately discontinued when the white blood cell counts revealed a leukopenia of 2,200, with a differential count of 10 per cent polymorphonuclear leukocytes, 2 per cent monocytes, and 88 per cent lymphocytes. Two days later the white blood cell count was 3,600 cells, with a differential count of 58 per cent polymorphonuclear leukocytes, 3 per cent eosinophils, 1 per cent monocytes, and 38 per cent lymphocytes. One week later the white blood cell count was 6,350, with a normal differential count.

His sixth attack, occurring in December 1945, and the seventh and up to the present, the final one in March 1947, at age of 15, were similar to the two previously described in that they were relatively mild and without skin manifestations, but were noteworthy in that the multitudinous and alarming array of pharmaceuticals previously used was discarded entirely, in favor of only one drug, namely, penicillin. The results obtained were excellent, but, I'm afraid, they cannot be attributed to the penicillin, since it was obvious from the first that the constitutional symptoms were mild, with scarcely any toxicity being present, and that rapid cure would occur even without the use of specific therapy. The white blood cell counts were 6,000 and 5,800 respectively. A white blood cell count one month after the sixth attack was 6,400. A white blood cell count five months after the last attack was 4,100.

Comment

Recurrences have been noted in previous reports of cases. Soll, in reviewing 22 cases reported in the English language, found recurrences in 3 cases, and in his own series of 20 cases had 2 with recurrences. Wright and associates reported 9 cases with six recurrences, altogether, an incidence of 21.5 per cent. As in the case presented, the recurrences were of the severe and mild varieties, and some, unlike this case, had a severe form following a mild initial attack.

The seasonal incidence of the cases reported in the literature varied, but the majority occurrd in the January to July months. Soll, in his series of 20 cases, had 18 occurring in that interval. Wright and associates had 8 out of his 9 cases with an onset in that period. Out of a total of the 29 cases cited above, 8 had an onset in January and 5 in February. The monthly incidence of onset in this case was as follows: March and August, twice each, and May, June, and December, once each.

The time interval between attacks varied from an interval of seven months to one of thirty-four months, the various intervals being as follows: seven, nine, fifteen, twenty-four, twenty-six, and thirty-four months respectively. There appears to be no definite correlation between the severity of the disease and the time interval, although it is interesting to note that the interval between the most severe attacks was two years or more, denoting, perhaps, an increase in immunity following the more severe forms of the disease.

The leukocyte count offers little as an aid in diagnosis. As a means of comparison, the leukocyte count in January 1947, during a routine check-up, fourteen months following an attack, was 6,400. In August 1947, five months following an attack, the leukocyte count was 4,100. So, we have, in this particular patient, a so-called relative leukopenia even during periods of normal health. The leukocyte count during the attack varied from a low of 2,200 during the mildest of the attacks, to a high of 9,600 during what was perhaps the most severe of the episodes. The differential counts were of no particular significance.

Treatment in this case has been relatively disappointing insofar as spectacular results or specific action of drugs is concerned. While it may appear that the use of pencillin was highly beneficial in each of the last two recurrences, the results must be viewed cautiously because from the onset the mild nature of the attacks was evident, and the conjunctivitis, toward which most of the specific treatment is to be directed, never went beyond the catarrhal stage and was never in need of specific therapy. However, in view of the results achieved by Wright and associates and Goldfarb, the use of penicillin should be given further clinical trial and evaluation.

More recently, literature[5] has appeared giving encouraging reports in the use of the antihistaminic drugs in the treatment of the various forms of erythema multiforme, and we have observed, in our own practice, very astonishingly rapid and spectacular recoveries following the use of Benadryl in mild cases of erythema multiforme bullosum. While the etiology of Stevens–Johnson disease is obscure, and appears to be, as most observers seem to think, an acute infectious disorder of virus origin, the possibility of an associated allergic state cannot entirely be ruled out; because of this, it is suggested that systemic antihistaminic treatment be carried out with topical use of penicillin in those cases in which the severity of the conjunctivitis warrants its use.

Summary

1. A case of Stevens–Johnson Syndrome with 2 major and 4 minor recurrences is reported.

2. The minor recurrences lack the toxicity, prostration, and exanthem which characterized the major attacks.

3. The time interval was longest between the major recurrences, denoting, perhaps, an immunity directly proportionate to the severity of the disease.

4. Recurrences were most common in the first half of the year.

5. Leukopenia was not characteristic of the disease. The leukocyte count was of no aid in diagnosis and was no index to the severity of the disease, the patient during the mildest attack having a leukocyte count of 2,200, and during the most severe, one of 9,600. The leukocyte counts in intervals of normal health were, on two occasions, 4,100 and 6,400 respectively.

6. Complete recovery followed each attack, irrespective of the therapy used.

7. Pencillin seemed very beneficial in two attacks, but the results were inconclusive since the disease was very mild in each instance.

8. It is suggested that antihistaminic drugs be given a clinical trial, because of rather spectacular results in the treatment of erythema multiforme and other types of erythema multiforme exudativum and because an allergic state may be present in the Stevens–Johnson disease.

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The Treatment of Infantile Paralysis During the Acute Stage*

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TREATMENT should be started as soon as the diagnosis of infantile paralysis is proved or strongly suspected. In addition to the family doctor or internist, an orthopedic surgeon should be summoned immediately. The success of the immediate orthopedic treatment depends upon meticulous care and unrelenting observation. Time may be the essence of success in treatment.

Rest

Rest is the one great essential in the immediate care. This not only must be complete and absolute, but must be managed so that the muscles placed at rest will be kept in a position of neutral pull. This is the most important factor in the prevention of later deformities and in minimizing residual disabilities. Complete rest is of such great importance during the early days of inflammation of the component parts of the central nervous system that it is usually far better to keep the child in bed at home when the disease is first suspected than it is to move him any appreciable distance to a hospital, especially if the trip may be rough. The fatigue and agitation which may result are harmful, especially in cases of bulbar paralysis. The decision should be based on the condition of each patient.

Deformity is largely preventable. In order to achieve this end, muscles must be protected from stretching and fatigue. A muscle placed at rest in a position of relaxation, with its attachments approximated, will recover sooner and more completely than will another muscle placed under tension.

Under no circumstances is massage or electrical stimulation to be used during the early acute stage. Not until the acute period is over should massage and the various forms of specific muscle training be started. (In general, the accepted dividing line between the acute and convalescent stage is the cessation of muscle and skin tenderness.)

Application of External Heat

Extremities should be kept warm. Applied heat will relieve muscle and skin tenderness. Heat will cause muscle pain to disappear more readily and will shorten the duration of the acute painful period.

In the acute sensitive stage one should employ hot applications. Woolen strips saturated with boiling water are "fished out" with a pole and run through a wringer twice. These are applied from one joint to another but not over the joint, in order to permit passive and active movements. These dressings are protected with oil silk and more dry warm wool. They are changed every half hour during the first twenty-four or forty-eight hours. This is continued twenty-four hours a day. After the extremely sensitive period has passed, the procedure is carried out from 8 a.m. to 8 p.m. and then only every two hours. The fomentations gradually cool. Small rolls of towel material are placed under the knees.

Gentle passive exercises are given, but never to the point of pain. The patient's activities are directed and concentrated in the area of the tendon, where movement is to be expected. After two passive movements, one active movement is attempted.

The Kenny theory of the situation in acute polio is based upon:

I. Muscle spasm
II. Incoordination
III. Mental alienation

Her procedure in correcting the situation includes:

I. No splints of any kind except a foot board
II. Hot fomentations
III. Muscle reeducation
IV. Avoidance of fatigue
V. Maintenance of proper positions
VI. Complete joint motion

The most important practical benefits derived from this treatment are relief from pain and sensitiveness and the prevention of contractures.

Primary Splinting

Any recognized type of splint which will maintain neutral positions can be used. In early poliomyelitis it is imperative to individualize the patients and to apply the measures appropriate in each case.

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The purposes of splinting are (1) to balance muscles and thereby retain neutrality of muscle pull; (2) to protect weakened muscles; and (3) to support limbs or other parts of the body.

Positions Favoring Optimum Return of Muscle Power

There are certain definite positions that are most desirable for the future usefulness of the limbs and trunk, a few of which are given here.

Fingers and Thumbs.—The proper position is that assumed in holding a drinking glass.

Wrist.—The wrist should be placed in slight extension (dorsiflexion).

Forearm.—The position of supination and pronation of the forearm is varied in accordance with the muscle weakness. The neutral position, which protects both pronators and supinators, is midway between pronation and supination.

Elbow.—The elbow should be flexed to a right angle. If the triceps is weak, it should be favored by keeping the elbow extended beyond a right angle. (This muscle is important in the later use of crutches.)

Moving and Turning the Patient.—During the first few weeks, it is advisable to move the patient as little as possible. It is important however, to prevent bedsores.

If the patient is on a straight Bradford frame, he may be turned on his face, with his feet hanging over the edge of the frame, provided the frame is elevated on blocks of wood which are high enough to prevent pressure of the toes on the bed.

The relation of the bed and bedside-table should be changed so that the patient will not repeatedly bend his trunk to the same side. Constant turning toward the same side may contribute to torticollis or scoliosis (if there is weakness of neck, abdominal, or back muscles). Repeated reaching to the same side to turn the dial of a radio may cause imbalance of the trunk muscles.

The child on a frame may be carried to any room in the house. He may rest on top of the kitchen table, on a bench in front of the window, or on the porch. He may even be taken out of doors on top of a coaster wagon. The head of the frame may be tilted at an angle, allowing the child to look about more easily, provided it is always in a safe position. An opening in the canvas, in the region of the buttocks, makes it possible for the patient to use the bedpan without disturbing his position.

In turning the poliomyelitic patient, twisting or torsion must be avoided. He should be handled as though he were a rigid object, like a poker which cannot be bent. The pelvic and shoulder girdles must turn as one unit. The nurses or attendants must not "wring" the patient as though he were a towel. A little traction and turning at the same time is often gratifying to the patient. The Stryker turning frame is very useful. The patient should be turned occasionally to prevent the formation of kidney stones.

Nursing Care

The patient must be kept in bed, with physical and mental quiet. To preserve rigidity and prevent sagging, several boards or a wood frame may be placed under one or two mattresses. An "illuminated" cradle should be used to keep the coverings off the feet and the limbs warm. The room should not be brightly lighted. The patient should be handled with extreme gentleness, since the limbs are often excessively tender and sensitive to movement. A many-handled canvas litter may be placed under the mattress to assist in transportation. Ice-bags applied to the back of the neck and to the spine for short periods sometimes relieve restlessness and pain. Sponging of the body should be done gently. The diet should be bland. The bowels must be kept open, but not with cathartics. Catheterization may be necessary.

Care of the Patient Immediately After the Febrile Stage

After first aid measures such as splinting and heat have been applied and other supportive measures and specific treatment have been instituted, *i.e.*, within a week or ten days, the temperature will usually revert to normal. At this time other measures can be instituted, to alleviate residual muscle tenderness, and one can continue with the further treatment.

Treatment by Warm Sea Salt Baths

Warm sea salt baths alleviate muscle and nerve pain. In some instances, they may be started very cautiously within seven days after the onset of the disease.

Completion of Physical Examination

It is often necessary for the physician to wait until most of the muscle tenderness has subsided before he can complete the physical examination and determine the extent of the muscle involvement. Thus a more accurate picture of the future outcome can be obtained. Because rest is so imperative in the very early stages, it is much better to postpone a complete muscle examination until soreness has largely disappeared. Irreparable harm can be done by the energetic use of active physical measures too early in an attempt to prevent paralysis. The prevention of further paralysis lies mainly in the early maintenance of neutral muscle positions. Only after a complete picture of the seriousness of the muscle involvement is obtained can one decide what further therapeutic measures should be employed.

Physical Therapy After the Acute Stage

Attention should be directed to the prevention of deformities by means of rest in proper positions, with constant supervision of the most minute details. The less patients are handled in the early stages, the better the results will be.

The majority of the patients are kept off their feet from ten to twelve months before they are allowed to attempt to stand or walk even with the support of braces and crutches. If, however, a patient is very slightly affected, his activities will depend largely on the return of power to the muscles of his trunk, pelvis, and lower extremities. He should probably be kept off his feet at least six months.

Muscle Training

Following an accurate muscle diagnosis and as soon as soreness of the limbs has disappeared, active muscle training is begun with exercises for five or ten minutes once a day. The aim is to prevent atrophy of the muscles due to disuse and to aid in restoring the function of these muscles by training unaffected nerves to carry on the work of the affected ones so far as possible.

Overuse of an affected limb is harmful. Early sitting and standing and constant efforts to move the muscles, urged by some cultists and unrecognized practitioners of physical therapy, are dangerous. There are no magic short cuts to recovery.

Assisted Movements

Muscle training consists in aiding the patient to perform a certain movement, in the hope of stimulating an impulse for the movement from the brain to the weakened or paralyzed muscle. The patient is told to send a voluntary impulse to contract a muscle, and the limb is placed in such a position that gravity will impel performance, or else the movement is assisted by hand. "A movement a day keeps adhesions away." In the first year following paralysis involving one or both legs, the best results follow non-weight-bearing exercises combined with little, if any, walking. In selected cases, however, the upright position with protected weight bearing and restricted walking have certain advantages over protracted inactivity.

Underwater treatment has been an important advance in handling poliomyelitis patients. Lowman allows the patient to begin underwater movements as early as the twenty-first day and to walk in deep water at the end of four or five weeks. The patient is submerged up to his neck. This improves his morale by eliminating pain, fear, and anxiety and by giving him pleasure. It restores balance and instills courage. The general health, sleep, and appetite improve. Nervousness diminishes. The buoyancy of the water minimizes fatigue of the weakened muscles. Ability to swim is a most valuable asset. Supervised swimming should be a part of the school drill. It is a sport in which the crippled child can equal others. Unsupervised swimming may cause much harm.

Light massage, if given by a person especially trained in the after care of infantile paralysis, is valuable. Good massage never wearies a patient. Massage improves the circulation and the tone of muscles.

Braces

A brace is a mechanical support whose purpose is to maintain a certain position of a portion of the body. A splint, strictly speaking, is a type of brace. Splints are used early in the acute phase of the disease to maintain neutral muscle position, to prevent later deformity, and to diminish pain.

Braces, on the other hand, are used during the chronic or residual phase to supplement a deficiency in function caused by weakness or paralysis of muscles and to prevent further deformity by furnishing adequate support and protection. Braces may also be used to correct deformity in selected cases.

Braces perform their greatest service either during the interval between the stage of maximum paralysis and such time as corrective operation can be performed, or after manipulation or orthopedic surgery has accomplished its final degree of correction.

The minimal requirements of an efficient brace are: (1) to furnish the highest degree of stability commensurate with the physical state of the patient, (2) to protect against imbalance caused by unequal pull of normal muscles against paralytic muscles, (3) to prevent further deformity caused by this imbalance, (4) to be of light enough construction to permit the patient to use it without undue fatigue, (5) to avoid pressure areas on the skin or bony prominences, and (6) to be within the financial reach of the patient or of an agency that will furnish it, without sacrificing durability.

Indications for Surgical Treatment

The purposes of operation are to improve muscle function, improve static stability, correct deformities, and make it possible for the patient to discard braces. In general, operations on poliomyelitis patients include osteotomies, arthrodesis, fusions, resections of bone, plastic operations, and tendon plastics and transplantations.

One should try to avoid major operations on patients before the age of 10 or 12 years. As a rule, no extensive operations should be performed within a year after the acute attack.

Operations on soft tissues include tendon release, tendon lengthening, tendon transplantation, tenodesis, muscle release and transplantation, silk ligament suspension, and fascial release and transplantation.

Operations on bones include osteotomy, tendon fixation, arthrodesis, arrest of epiphyseal growth, bone lengthening, and bone shortening.

Remarks

The six most important considerations concerning poliomyelitis are, first, a reliable test for the early diagnosis, *i.e.*, before paralysis occurs; second, the isolation, identification, and complete information concerning the virus; third, a protective vaccine; fourth, serum or other substances that can be given

before paralysis has occurred; fifth, maintenance of joints in positions of neutral muscle pull; and, sixth, the application of external heat.

One may reasonably hope that, by improved knowledge, the diagnosis will be made in the preparalytic stage, and in future epidemics lives will be saved, deformities will be prevented, and disability will be minimized.

The following are a series of what I have called the Postulates of Polio or Poliograms:

The child of today is the grown-up of tomorrow.

The future of the race marches forward on the feet of little children. (Brooks)

One pair of legs must last a lifetime.

Position is everything in the life of a limb.

A splint in time saves days of disability to the number of ninety and nine.

Every major deformity can be prevented.

Poliomyelitis is the most dreaded of all the infectious diseases that attack children.

The outlook depends upon the nerve damage and the care that is given to the muscles supplied by those particular nerves.

The year 1947 gave us a polio breathing spell, but we haven't one bit of scientific assurance that 1948 will be as kind.

Statistics indicate that poliomyelitis attacks only one child in every 10,000 of population, which makes its appearance 1/100 of 1 per cent, but if it affects your child, for you, your family, and your child, it is 100 per cent.

Lightning never strikes twice in the same place, but poliomyelitis might.

Because his feet hurt and no one would buy him a new pair of shoes, a beggar was complaining bitterly, until he saw another man, whose legs were paralyzed and deformed by infantile paralysis, offering prayers because his life had been spared.

A splint in time saves the child's weight-bearing line.

Orthopedic care begins immediately after the diagnosis is made or suspected.

No major deformity should be permitted to occur.

The world acts and reacts upon us in many ways, but we act on it in only one way—by muscular action.

Our brains would be worthless if we didn't have muscles to perform the acts prescribed by the brains.

Muscles are the creatures of habit and the slaves of custom.

Your daily reactions must be translated into muscle actions.

If deformity is not prevented, it must be corrected; and if disability is not prevented, it must be treated.

There is no condition that compares with poliomyelitis in developing fortitude.

The other day a lady went to a children's hospital to visit the infantile paralysis clinic. There is something remarkable about the philosophy which these children develop in the face of pain. They have to show so much character to overcome their handicaps. One little boy told me he had to do exercises with his arm every day because he couldn't throw a ball. The lady told him that if he kept at it steadily, some day he would find that the power had returned, but what she didn't tell him was that the character he would develop by sticking to those daily exercises would serve him better in after life than almost anything acquired in school. That lady was Mrs. Eleanor Roosevelt.

Beware of impure water and unpasteurized or uncertified milk. Wash or thoroughly wipe the outsides of milk bottles before removing the cap and pouring the milk.

Wash, peel, or scrape all fruits and vegetables.

Wash your hands before eating.

Avoid flies, insects, vermin, polio contacts, and carriers.

Be sure of the disposal of garbage, sewage, and excreta.

Instruct children to avoid putting pencils or other articles in their mouths.

Avoid sick children; avoid children's gatherings, especially during the summer and autumn.

Every child should have a maximum of fresh air, sunshine, and rest periods.

When a sick child complains of headache, stiff neck, backache, stiff back, think of polio. Call a physician. If he is perplexed, ask to call another doctor in consultation.

Keep polio in mind; you can find something more quickly if you keep thinking of that for which you are looking.

Some cases require the teamwork of the general practitioner, pediatrician, laboratory worker, neurologist and orthopedic surgeon.

Complete rest is so important that it is usually far better to leave the patient in bed at home, when the disease is first suspected, than to move him any appreciable distance to a hospital. This is especially true in cases of bulbar paralysis.

When the diagnosis of polio is made or suspected, splint, protect, and support the joints in position of neutral muscle pull and keep the tissues warm.

Immediate orthopedic protection and support prevent deformity and minimize the disability. Prevent deformity by maintaining joints in neutral or normal positions by splints, sandbags, saltbags, and pillows.

Unsupervised swimming is not synonymous with underwater gymnastics.

When nature "falls down on the job," she falls very hard.

Proper splinting is assurance against any major deformity and may avoid surgical operations.

Avoid fatigue and chilling of nerves and muscles; if a child has Polio he must rest.

If the back, buttock, and leg muscles are extensively affected, do not permit standing or walking for one year.

Have patience. Never give up. Keep up the patient's morale.

In no child with polio today should a major deformity develop if the proper orthopedic treatment is prescribed immediately and continued during the well established period of the disease.

Due to an intensive campaign of study, research, practice, and education we can now promise a mother that every major deformity can be prevented. We can say to a mother, "If your child becomes seriously deformed it will be because you and we have not been sufficiently careful or cooperative."

Recent Advances in Poliomyelitis*

(*S. O. Levinson*)

1. Transmission of human strain of polio virus to cotton rat and mice (Lansing).
2. Isolation of polio virus from stools of patients.
3. Isolation of polio virus in sewage.
4. Isolation of polio virus from flies trapped in infected areas.
5. Demonstration of antigenically different strains of human polio virus.
6. Isolation of polio virus from stools up to four months after recovery from illness.

* Thanks to Dr. S. O. Levinson are expressed by the author.

7. Isolation of polio virus from stools of contacts and abortive cases.
8. Production of experimental poliomyelitis by feeding virus to chimpanzees and to Cynomolgus monkeys.
9. Isolation of virus from the blood stream of an inapparent infection in man.
10. Isolation of virus from mucosa of the intestinal tract and from mesenteric lymph nodes.
11. Establishment of a correlation of heavy incidence of bulbar poliomyelitis following tonsillectomy, appendectomy, and in cases in which there is exposure of the pulp of teeth.
12. Experimental production of bulbar poliomyelitis in monkeys following tonsillectomy, and the injection of virus into the tissues of the tonsillar fossa.
13. Experimental evidence that fatigue and chilling are predisposing causes of the incidence and severity of poliomyelitis.
14. The production of a totally inactivated polio vaccine which is highly immunogenic in mice.
15. Demonstration that heat is of value in acute poliomyelitis in relieving pain and tenderness.
16. Radical modification in the application and use of splints in acute poliomyelitis.
17. Successful transmission of and adaptation to mice of other strains of poliomyelitis virus.
18. Demonstration of myocardial pathology in fatal bulbar poliomyelitis.
19. Demonstration of increased resistance of mice to the Lansing virus when a thiamin-deficient diet is employed.
20. Concentration and purification of polio virus by high-speed centrifugation in the ultracentrifuge.

Negative Contributions

1. Therapeutic inefficacy of sulfonamide drugs and other antibiotics so far tested.
2. Demonstration that amounts of chlorine employed to purify drinking water fail to destroy the poliomyelitis virus.
3. Nasal sprays for prevention of poliomyelitis of no value in man.
4. Efforts to cultivate human strains of poliomyelitis virus in chick embryo or tissue culture have thus far failed.

Headaches and Head and Face Pains*

By W. J. FRAWLEY, M. D.
Appleton

W. J. FRAWLEY

Doctor Frawley received his medical degree from the Chicago College of Medicine and Surgery in 1915. Following internship he served in the Army Medical Corps from 1917 to 1919, returning to specialize in treatment of the eye, ear, nose, and throat. Since 1931 the doctor has been associated with the Appleton Eye, Ear, Nose, and Throat Clinic at Appleton.

WHAT has prompted me to prepare a paper on this subject is the great number of patients who come into my office and your office with a self diagnosis of a sinus headache or eye strain headache. During the days when we all have been busier than we should be, I feel that we have sort of neglected these patients who are definitely in need of assistance. Very often a patient reports to the office who has had a very thorough competent examination by a general practitioner, with a report that he has a negative urinalysis, negative blood picture, and no hypertension. All pathologic signs have been eliminated except his sinuses or eye strain.

The first and most important thing, I feel, is to get a complete history—spend more time on it than we all have been giving to it. Find out the time of day the patient has these headaches, the frequency of recurrence of the headaches, and if they follow or precede menstrual period in the female patient. It is also very important to get the family history if this has been a chronic condition in members of his or her family. I feel that a thorough history, especially in regard to allergies, is of much more importance than skin tests: history of headaches after thermal changes, working in a warm place and getting in a draft, sitting in front of an electric fan, etc. After a very thorough history has been completed, one probably can eliminate certain conditions, and also definitely feel that it may be a positive migraine.

In general, it may be said that all pain relative to the head and face must be the result of a pathologic process that either directly or indirectly stimulates the sensory nerve supply of one or more of these regions. From an otolaryngologic point of view, the origin of the local or referred pain may or may not be demonstrable. When the former is the case, a pathologic process can be demonstrated which exists in the ear, nose, throat, and sinuses or the temporomandibular joint, toward which appropriate therapy can be directed, with the result that the alleviation of pain occurs in the majority of cases. When etiology is not decisive, however, the problem is more complex. It is in such cases that familiarity with the symptomatology of various general systemic and intracranial diseases as well as of local infections in the head, throat, and cervical muscles

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

should be evaluated and also those of the cervical and sympathetic nerves.

Pain of otolaryngologic origin is most conveniently considered with respect to its location. Pain in or about the ear may have its etiology either in a pathologic process actually involving the ear or in one that is situated elsewhere but from which the pain is referred to the ear. Acute external otitis, furunculosis, acute or chronic suppurative otitis media, acute or chronic mastoiditis, and neoplastic diseases of the external auditory canal or middle ear are samples of the former and require no elaboration.

It is more difficult to establish the source of pain when it is referred to the ear of its vicinity. Thorough examination of the ear, nose, throat, sinuses, and temporomandibular joint may reveal that the origin of the referred pain is acute tonsillitis, a peritonsillar abscess, acute salpingitis of the eustachean tube, an acute inflammatory disease of the larynx, a neoplasm, an abnormality of the temporomandibular joint, or an ulcer in the throat. Also, it is well to remember that an explanation may be found in the existence of a neuralgia of the sphenopalatine ganglion or the glossopharyngeal, superior pharyngeal, or auricular nerves.

In spite of the fact that a majority of patients who consult us because of head pain or face pain are firmly convinced that their sinus is the explanation of the pain referrable to the forehead, nose, or cheek, probably in not more than 10 per cent of all cases can head pain satisfactorily be explained on this basis. It is well to remember that not all sinus diseases are productive of pain. Acute infections of the sinuses, particularly those of the maxillary and frontal, usually are more prone to be manifested by pain than are chronic infections. When pain is present, it is most likely to be located over the site of the sinus infection and usually can be intensified by pressure on the anterior wall of the sinus. Occasionally maxillary sinusitis may cause pain referred to the teeth. Ethmoid sinusitis gives rise to pain located around the root of the nose, above the inner canthus of the eye, and in the temporal region. Pain from sphenoid sinusitis is usually located deep in the head behind the eyeballs, in the vertex, and in regions of the ear.

A diagnosis of sinusitis is made by careful clinical examination of the nose and the postnasal space and x-ray study, but whether or not the pain of which the patient complains is caused by sinus infection can be ascertained only after suitable therapy directed toward the sinusitis has resulted in cure of the sinus infection and relief of the pain.

Conditions other than sinus infection may produce pain over the nose, about the eye, and in the cheek and teeth. Neuralgia of the sphenopalatine ganglion presents symptoms referrable both to the ear and to the nose. A typical history of sphenopalatine ganglion neuralgia includes all or part of the following: The pain is always unilateral and never extends above the level of the ear. It is usually lancinating and continuous, lasting from a few minutes to several days, recurring after no special interval, and always more or less repeating the previous episode. There are usually two main points of maximal pain —one in the region of the orbit and the root of the nose, and the other just posterior to the mastoid process.

If cocainization of the sphenopalatine ganglion gives relief from pain in two to three minutes, the diagnosis is conclusive.

Neoplastic diseases of the sinus are more prone to be productive of head pain than is infection of the sinuses, and the pain is not relieved by appropriate sinus treatment. The diagnosis can be definitely arrived at by x-ray examination which reveals destruction of the bone of the sinus wall. Abnormalities of the nasal septum of such a character as to permit contact of septal mucosa with that of the lateral wall of the nose on the middle turbinate high in the nose frequently cause pain or discomfort over the dorsum of the nose and the region of the glabella or above the inner canthus of the eye, Whether or not such a deviation of the nasal septum is responsible for the production of pain can usually be ascertained by shrinking with ephedrine, and, if relief of the pain is obtained in this way, an adequate submucous resection of the nasal septum will give permanent relief.

I feel very definitely that there has been a decided trend in blaming any and all pain in the head and face to allergy and that we are all neglecting septal deformities, especially spurs, which do not seem to interfere much with ventilation; but, because the pressure maceration of the intranasal mucosa is frequently responsible for the severe, recurrent pain and headaches, I feel that these deformities are too frequently by-passed by the otolaryngologist as unimportant.

There are a few definite conditions that I want to outline in concluding this paper.

Migraine

Characteristics of typical migraine are well known. It occurs in attacks lasting two to three hours or two to three days, usually located in one side of the head, forehead, or face. It is accompanied by visual disturbance and vomiting. Correct diagnosis must depend on a careful review of the history to get the whole picture. The one evidence of greatest importance is the occurrence of the headache and repeated isolated attacks of limited duration with complete remission in the intervals. Preventive measures must depend on proper revaluation of the contributing factors, including nervous strain and fatigue, eye strain, and food allergy, with adoption of measures to correct them.

I am not going into a discussion of the treatment of migraine, but even if the recurrence of the attacks cannot be wholly prevented, merely to establish the diagnosis of migraine is a substantial help in a great many cases. The patient will be spared needless anxiety about conditions threatening life

and health. It will also keep him from treatment by chiropractors and other cults.

Histamine Cephalalgia

This is a condition formerly considered a type of migraine but now recognized as histamine cephalalgia, first described by Doctor Horton of Mayo Clinic in 1939. It is characterized by attacks of acute pain rather than headaches, located on one side of the face or forehead, and accompanied by local edema, lacrimation, and nasal congestion. It occurs each day in cycles lasting weeks or months. Desensitization by injections of graded doses of histamine is recommended in cases of daily occurrence of pain over a prolonged period. Horton's plan is to give injections twice daily, starting with a 0.10 cc. of solution, to be increased to a maximum of 1 cc., but a good deal of care is necessary in observing the patient with the gradual increase of the dosage. I have found that Pyribenzamine and Benadryl are most effective. The usual dosage of either is 50 to 100 mg. three times a day.

Hypertension Headache

Patients with high blood pressure often complain of headaches, but in my opinion their complaint is more often due to causes other than the hypertension, such as nervous tension and migraine. The headache related to blood pressure is likely to occur each morning soon after awakening and gradually wear away during the day.

Myalgia of the Head

Another explanation has been proposed by Doctor Williams of Rochester, Minnesota, who attributes many of the so-called sinus headaches to physical allergy involving muscles in relation to the head and neck. Important evidence for such condition is (1) history of occurrence of symptoms on exposure to physical stimuli such as drafts, changes in temperature, and change in atmospheric pressure. Williams has reported benefit from treatment with Niacin in 54 out of 72 cases. He used 25 mg. by hypodermic injection, increasing the dosage up to 100 mg. daily. Also, he feels that treatment with Benadryl and Pyribenzamine and desensitization doses of histamine are of some value.

Brain Tumor

Anyone will suspect a brain tumor when there is a constant progressive localized headache with change in personality, loss of vision, and vomiting. Proof may be furnished by finding choked disks, evidence of increased intracranial pressure or other changes on x-ray of the skull, increased pressure, and increased protein in the spinal fluid. However, it must be emphasized that a brain tumor may be present without any of these symptoms or signs. I feel there must be awareness of possibility of a brain tumor when a person formerly free from headaches begins to suffer from chronic ache or pain in the head in adult life, especially when the complaint becomes worse in spite of the usual treatment. These patients should be referred to a neurologist for consultation and recommendation.

One of the encouraging features that I have experienced in working on these items of headaches and head and face pains is the gain which has been made in accuracy of diagnosis, illustrated by the identification of new clinical entities such as histamine deficiency and temporal arteritis and the recognition of the significance of conditions such as herniated intervertebral disk, occipital neuralgia, and intracranial aneurysms. The resulting treatments are still far from successful in many cases, but there is satisfaction in a survey of the substantial progress which has been made in arriving at a diagnosis of these obscure headaches and head pains.

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS TO PRESENT PANEL DISCUSSION

All Wisconsin physicians are invited to attend a panel discussion of the autonomic nervous system as it is concerned in all surgical operations, which will be presented by the Wisconsin Society of Anesthesiologists, September 19, in the auditorium of the Service Memorial Institutes Building, 426 North Charter Street, Madison. The program will be as follows:

10:00–11:00 a. m.: Panel I—"Anatomical Considerations of the Autonomic Nervous System." Moderator: F. D. Geist; Panel: H. M. Suckle, W. D. Bennett, R. M. Wylde.

11:00–12:00 a. m.: Panel II—"Physiological and Pharmacological Considerations of the Autonomic Nervous System." Moderator: O. S. Orth; Panel: F. D. Geist, S. S. Burke, Jr., L. E. Morris.

12:30 p. m.: Luncheon

2:00– 3:00 p. m.: Panel III—"Changes Attributable to the Autonomic Nervous System During Surgical Operations." Moderator: G. Shortz; Panel: H. M. Suckle, R. M. Waters, R. A. Tella.

3:00– 4:00 p. m.: Panel IV—"Blocks of the Autonomic Nervous System as Therapeutic and Diagnostic Aids." Moderator: R. A. Tella; Panel: G. Shortz, D. D. Waters, R. M. Wylde.

Each hour will consist of an introductory discussion by the moderator outlining the subject matter, followed by short discussions by each of the panel members. For the remaining time, questions and additions will be directed from the floor.

The advance registration fee will be $1.00. Luncheon reservations, which must be made in advance, will cost $2.00. Residents in hospitals are invited without fee, but are requested to make reservations in advance. Communications should be addressed to Dr. William Kreul, 811 Main Street, Racine, Wisconsin.

Acute Obstructive Cholecystitis*

By PAUL C. KIERNAN, M. D.
Washington, D. C.

P. C. KIERNAN

Doctor Kiernan, who is at present associate professor of surgery at Georgetown University School of Medicine, was formerly head of the Section on Surgery at Mayo Clinic, Rochester, Minnesota. He received his medical degree at George Washington University School of Medicine, Washington, D. C., and later obtained a master of science degree in surgery from the University of Minnesota Medical School. He has been certified by the American Board of Surgery

THE diagnosis and management of acute obstructive cholecystitis constitute a problem of major importance to every physician and surgeon, for this disease comprises about 20 per cent of all diseases of the biliary tract encountered in medical and surgical practice.

The risks of acute cholecystitis can be minimized if chronic cholecystitis with stones is diagnosed and evaluated properly. A history of cholecystic disease manifested by biliary colic and cholecystographic evidence of stones or a nonfunctioning gallbladder is sufficient evidence to indicate surgical treatment except, of course, for the patient whose general condition will not permit operation. Personally, I am convinced that there is no such thing as the so-called innocent gallstone and that such should be removed.

In a series of 102 cases of acute obstructive cholecystitis at the Mayo Clinic, in 73.5 per cent previous history of biliary colics and indigestion was given.

Of 150 patients who had cholecystic disease in which a nonfunctioning gallbladder was reported after cholecystographic study and who refused surgical treatment, 27 per cent were reported by Clagett[1] to have been operated on for serious complications of the disease such as jaundice, pancreatitis, and perforated gallbladder within two years.

The time for removal of gallstones is, as is pointed out by Marshall,[2] when the condition is diagnosed. Then, when operation is performed as an elective procedure, the operative risk is minimal.

It is readily admitted by all physicians that acute obstructive cholecystitis is primarily a surgical condition, but whether it should be treated by immediate or delayed operation is debated by many. I am of the opinion that no rigid rules of treatment should be made in regard to the time of operation but that each case should be given individual consideration, a point stressed by Zollinger and Cutler.[3]

In general, each instance should be treated as an emergency and the patient should be hospitalized immediately and with minimal delay prepared for operation. Time should be taken to get the patient in the best possible condition for operation, and complicating factors should be dealt with properly. I do not believe that it is necessary in the great majority of cases to operate within a number of hours, because conditions may not be optimal in that period. If the patient is seen early in the course of the disease and is hospitalized immediately, surgical exploration usually can be carried out very safely within the first forty-eight to seventy-two hours. It has been my experience that operation performed during this time is far from hazardous or difficult, but rather it is oftentimes made easier by the presence of watery edema which surrounds the gallbladder and ducts and which aids in the dissection and control of bleeding. If operation be delayed for a week or more, these tissues become friable and more difficult to work with. Often when the condition has been handled conservatively and surgical treatment delayed for weeks or months, in spite of the fact that all evidence seems to indicate that the inflammatory component has abated completely, one finds conditions at their worst and, because of induration about the hepatoduodenal ligament which makes accurate identification of structures too difficult and hazardous, must be content simply to drain the gallbladder.

I agree with Eliason and Stevens[4] that the surgeon should recognize his own limitations as well as the patient's condition and that, unless conditions are favorable for cholecystectomy, cholecystostomy is the procedure of choice. Emptying the gallbladder by trocar and cannula is a great aid in getting rid of the distention and in allowing for more adequate exposure and easier manipulation.

The diagnosis of acute cholecystitis is not difficult, but care and time should be taken to rule out conditions such as coronary occlusive disease, diabetes mellitus, and pancreatitis, which would contraindicate immediate surgical treatment.

Study of 102 Cases

Age and Sex Incidence.—In the 102 cases of acute obstructive cholecystitis encountered at the Mayo Clinic between January 1, 1942, and December 31, 1946, 57 per cent of the patients were more than 50

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

years of age, the youngest and oldest being 21 and 83 years old respectively.

In contrast to the situation in most of the series reported, there were more males than females in this group (ratio of 9:8).

Signs and Symptoms.—As was previously stated, 73.5 per cent of the patients gave a previous history of biliary colic and indigestion.

In one third of the cases the temperature was 101 F. or higher, and in approximately two thirds, an elevation of the leukocyte count to more than 10,000 per cubic millimeter of blood was noted.

Jaundice was present on admission in 20 cases (19.6 per cent). This compares with an incidence of 17 per cent noted by Lester.[5] The history of jaundice was obtained in a higher percentage of cases but, because in many instances it seemed quite questionable, was not recorded.

The gallbladder was palpable in 43 per cent of the cases.

Acute pancreatitis was a concomitant diagnosis in 4 cases. Three of the patients in these 4 cases were operated on after the pancreatic inflammatory component was allowed to subside as indicated by estimation of the serum amylase. In the fourth case of acute cholecystitis, in which the value for serum amylase was 4,000 units, the patient's condition was thought to be too poor for surgical treatment and the patient subsequently died.

Treatment and Operative Findings.—Eighty-seven of the 102 patients were operated on. The hospital mortality rate was 1.1 per cent (table 1). Of the 15 patients who were not operated on, 5 refused operations, the condition of 5 improved and surgical

TABLE 1.—*Surgical Procedures in 102 Cases of Acute Obstructive Cholecystitis (1942 through 1946)*

Surgical Procedure	Cases	Hospital Deaths
Cholecystectomy	68	1
Cholecystostomy	19	0
None	15	3

treatment was deferred, and 5 were thought to be too ill. Three of this last group died and postmortem examinations were made. Therefore, in 90 cases the pathologic state of the gallbladder was definitely known. In these 90 cases, stones were found in 95.5 per cent.

In the 20 cases in which jaundice was present, exploration of the common duct was carried out in 14 without mortality and one or more stones were removed in 64 per cent.

In the 87 cases in which surgical treatment was given there seemed to be little or no correlation between the operative procedure and duration of the disease (table 2). If patients were operated on within seventy-two hours of the onset of the disease, the time of operation was classified as immediate, within four to seven days as early, and more than seven days as delayed. Cholecystectomy or cholecystostomy was performed in approximately the same percentage of cases in the immediate and delayed groups.

TABLE 2.—*Relationship of Duration to Type of Operative Procedure*

Time of Operation	Cases	Operation			
		Cholecystectomy,		Cholecystostomy,	
		Cases	%	Cases	%
Immediate	28	23	82.1	5	17.8
Early	11	7	63.6	4	36.4
Delayed	48	38	79.2	10	20.8
Total	87	68	78.2	19	21.8

Complications.—As is seen in table 3, the incidence of the two major complications, gangrene and perforation, at the time of operation, was twice and three times as high in the delayed as in the immediate groups. This fact was stressed by Root and Priestley. In addition, gangrene and perforation were found at postmortem examination in each of the cases in which the patient died without having undergone surgical exploration. Each of these had been ill longer than seven days at the time of death.

TABLE 3.—*Incidence of Gangrene and Perforation in Relation to Time of Operation*

Time of Operation	Cases	Gangrene,		Perforation,	
		Cases	%	Cases	%
Immediate	28	9	32.1	3	10.7
Early	11	8	72.7	1	9.1
Delayed	48	32	66.6	15	31.2
Total	87	49	56.3	19	21.8

The total incidence, therefore, of gangrene and perforation was 51.0 and 21.6 per cent respectively. The incidence of gangrenous cholecystitis in this series is high when compared with that in others. The incidence in Wallace and Allen's[7] series was 29.4 per cent. Cowley and Harkins[8] reported an average incidence of perforation of 13.0 per cent in a series of 2,261 cases of acute cholecystitis. One possible explanation of the high incidence of gangrene and perforation is that our series actually represents a selected group of cases. The great majority of patients came from a distance, and in one half of the cases operation was delayed. The patients obviously had survived the initial risks of the disease which prevented others from coming to the clinic.

The several types of perforation are shown in table 4.

There is some correlation (table 5) between the fever and leukocytosis and the pathologic state of the gallbladder, but it is certainly impressive and worth noting that in 61.5 per cent of the cases in which the gallbladder was gangrenous and 40.9 per

TABLE 4.—*Types of Perforation*

Type	Cases	%*	Hospital Deaths
Acute free perforation	5	5.6	3
Subacute perforation with pericholecystic abscess	12	13.3	0
Perforation into a viscus	2	2.2	0
Impending fistula	3	3.3	0
Total	22	24.4	3

*Of 90 cases in which pathologic findings were available.

cent of those in which it was perforated the temperature was less than 101 F. and a practically normal leukocyte count was found in 23.1 per cent of the cases in which the gallbladder was gangrenous and 18.2 per cent of those in which it was perforated. Wallace and Allen found no reliable criteria to indicate the presence of these two complicating conditions. Eliason and Stevens noted that the pathologic state of the gallbladder could not be estimated safely by any physical or laboratory tests. A disease which can so well mask itself must be looked on with great concern and every attempt made to operate before these complications occur.

TABLE 5.—*Fever and Leukocytosis in Cases in which the Gallbladder was Gangrenous or Perforated*

	Cases	Fever,*		Leukocytosis,[2]	
		Cases	%	Cases	%
All cases	102	34	33.3	66	64.7
Gangrene	52	20	38.5	40	76.9
Perforation	22	13	59.1	18	81.8

*Temperature: more than 101 F.
[2]Leukocyte count: 10,000 or more per cubic millimeter of blood.

Seven patients in 87 had postoperative complications of major degree. Of these 7, only 1 was less than 50 years of age. In all 7 cases cholecystectomy was performed, and in 1, choledochostomy was performed. Two instances of pulmonary infarction and 2 cerebrovascular accidents were encountered in 4 cases. These conditions were satisfactorily treated with anticoagulants (dicumarol). Atelectasis occurred in 1 case and responded to conservative treatment. In 1, postoperative wound separation necessitated secondary closure, and in 1 a second operation (enterostomy) was necessary for the relief of postoperative bowel obstruction. There were no deaths in this group.

Mortality.—In the 102 cases there were four deaths (3.9 per cent). In the 87 cases in which surgical treatment was given, 1 patient (1.1 per cent), aged 49 years, died while on the operating table. Of the 15 patients who did not undergo surgical treatment, 3 (20 per cent) died of the disease or its complications. In each of these 3 cases a perforated gangrenous gallbladder was found at postmortem examination.

Summary

The records of 102 cases of acute obstructive cholecystitis encountered in a five year period were studied. The over-all mortality rate was 3.9 per cent, 1.1 per cent in the group in which surgical treatment was given, and 20 per cent in the group in which surgical treatment was not given. Seventy-three and five-tenths per cent of the patients gave a history of previous biliary colics and indigestion. Fifty-four of the patients were males, and 48 were females. Fifty-seven per cent of the patients were more than 50 years of age. Significant fever (temperature: 101 F. or more) was present in one third and leukocytosis (leukocyte count: 10,000 or more per cubic millimeter of bloods) in two thirds of the cases. In 61.5 per cent of the cases in which the gallbladder was gangrenous and 40.9 per cent of those in which it was perforated, the temperature was less than 101 F. and a practically normal leukocyte count was found in 23.1 per cent of the cases in which the gallbladder was gangrenous and 18.2 per cent of those in which it was perforated. Jaundice was present in 19.6 per cent of the cases when the patients were admitted. Palpable gallbladders were noted in 43 per cent. Acute pancreatitis was present in 4 cases.

In the 87 cases in which surgical treatment was given, cholecystectomy was performed in 68 and cholecystostomy in 19. Choledochostomy was performed in 14 of the 20 cases in which jaundice was present, and one or more stones were removed from the common duct in 64 per cent. In the 87 cases in which surgical treatment was given, plus 3 in which the patient died before surgical treatment could be given, stones were present in 95.5 per cent. There was no correlation between the operative procedure and the duration of the disease. The incidence of gangrene and perforation was twice and three times as great respectively in the cases in which surgical treatment was delayed as in those in which it was given early. In 7 cases postoperative complications occurred; none of the patients died.

Conclusions

1. The risks of acute obstructive cholecystitis would be minimized by proper treatment (operation) in all cases of chronic calculous cholecystitis regardless of the patient's age, excepting only those cases in which operation is contraindicated because of the presence of some other condition which makes the surgical risk greater than the risk resulting from the presence of cholecystic disease.

2. There may be little correlation between the physical signs and the pathologic findings in acute gangrenous perforating cholecystitis.

3. Early operation is the treatment of choice, but individualized consideration must be exercised in the proper evaluation of the patient's condition and care of the complicating factors in preparation for surgical treatment.

4. The question of whether cholecystectomy or cholecystostomy should be performed should be

decided on the basis of the limitations of the surgeon and the condition of the patient.

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WISCONSIN CHAPTER OF AMERICAN COLLEGE OF CHEST PHYSICIANS TO MEET

The fourth annual meeting of the Wisconsin Chapter of the American College of Chest Physicians will be held at the Hotel Schroeder, Milwaukee, on October 3, the day preceding the Annual Meeting of the State Medical Society. There will be no registration fee, and all physicians are invited to attend the program, which will be as follows:

1:30 p. m.: Registration, Crystal Ball Room

2:00 p. m.: Scientific Session

"Pneumoconiosis, Pulmonary Emphysema, and Cor Pulmonale"

Norbert Enzer, M. D., F. A. C. P., director of laboratories, Mount Sinai Hospital, Milwaukee; consultant in industrial medicine

"Pulmonary Function in Bronchial Disease"

Edwin R. Levine, M. D., F. C. C. P., director of chest service, Michael Reese Hospital; medical director, Winfield Sanatorium, Chicago

"Bronchiectasis, Its Diagnosis and Surgical Treatment"

William A. Hudson, M. D., F. C. C. P., associate professor of clinical surgery, Wayne University College of Medicine; attending surgeon, Detroit Tuberculosis Sanatorium, Detroit

"Comparison of the Effect of Penicillin, Sulfadiazine, and the Combination of Penicillin and Sulfadiazine in the Treatment of Lobar Pneumonia"

Italo F. Volini, M. D., F. C. C. P., F. A. C. P., professor of medicine, Loyola University School of Medicine, Chicago

"Fungus Diseases of the Lung" (with motion picture demonstration)

Arthur Q. Penta, M. D., F. C. C. P., director, department of broncho-esophagology, Schenectady City Hospital, Schenectady, New York; lecturer, Temple University School of Medicine, Philadelphia

"Pitfalls to the Early Diagnosis of Carcinoma of the Lung"

Allen Good, M. D., roentgenologist, Mayo Clinic, Rochester, Minnesota

6:00 p. m.: Dinner Meeting, Pere Marquette Room

Address: "Protection of Medical and Nursing Personnel in Hospitals"

J. Arthur Myers, M. D., F. C. C. P., F. A. C. P., past-president, American College of Chest Physicians; professor of medicine and public health, University of Minnesota Medical and Graduate Schools, Minneapolis

8:00 p. m.: X-ray Conference, Pere Marquette Room

Address: "Metastatic Tumors of the Lung"

Jerome L. Marks, M. D., roentgenologist, Milwaukee County General Hospital, Wauwatosa

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Treatment of Brucellosis

Brucellosis is a stubborn and unpredictable disease which has constituted a long time challenge to students of specific chemotherapy. Each new chemotherapeutic agent has been tried in cases of this disease, with results ranging from apparent startling success to dismal failure. One may suspect that seeming successes often may have been ascribed to the virtues of a new drug, when, on further attempts, keen disappointment followed the failure to confirm earlier hopes. The capacities of patients themselves must have been concerned, since many people undoubtedly have been adequately exposed but a clinically detectable infection has not developed; others revealed infections whose course of symptoms cleared concurrently with treatment, and finally patients were found who failed to respond to any known therapeutic agent, even to sulfadiazine or, later, to streptomycin. This situation has plenty of precedents. Digitalis does not always fulfill expectations. Antisyphilitics do not always cure syphilis, and similarily for all the rest of the agents used for serious therapeutic purposes. Advances in therapy have been dramatic in recent years; yet 100 per cent of cure is biologically a hope not likely ever to be attained.

Within the past two or three years it became evident that the promising new antibiotic, streptomycin, ran true to form and led to disappointments in certain cases, as also had been the situation when the sulfonamides, the choice of which seems to have been sulfadiazine, were studied.

Following the general precedent set by the ancients, namely, the concurrent use of two or more different drugs, the more recent advances in therapy of brucellosis involve the combined activity of the two drugs, streptomycin and sulfadiazine. C. W. Eisele and N. B. McCullough have recently reported a careful study of a case of brucellosis of such a nature that spontaneous remissions would appear to have been extremely unlikely owing to constancy of manifestations, including demonstrable organisms of Brucella in the blood, and constant clinical manifestations of the continuing disease.

A series of four courses of streptomycin, making a total of 128 Gm., failed to clear the blood of bacteria even though tests of susceptibility, *in vitro*, demonstrated the organisms to be normally susceptible to the drug. Actually the blood contained a concentration of streptomycin that was from three to five times that required to kill these very organisms *in vitro*. Pulaski and Sprinz suggest that neither streptomycin nor sulfadiazine penetrates into the lymph glands, spleen, and perhaps other loci of tissue infection in concentrations adequate to destroy the bacteria and hence the organisms are fed back into the blood stream. Most of these bacteria developing in tissues apparently have not developed drug resistance or fastness owing to lack of necessity and exposure. This supposition would seem to explain the paradox of high concentrations of drug in the blood, in which the recoverable bacteria reveal no altered tolerance as measured by *in vitro* tests.

In the case studied by Eisele and McCullough, there was administered in the last course of treatments, 4 to 12 Gm. of sulfadiazine per day for a period of eighteen days without clinical or other signs of improvement. The drug concentration in the blood was approximately 10 mg. per hundred cubic centimeters of blood. This period was followed immediately by a ten day series of treatments with the additional administration of streptomycin in 6 Gm. doses daily, intramuscularly. The fever disappeared promptly and remained so for a few days, then rose again, to disappear on complete cessation of all treatment. Evidently the fever was due to one or other of the drugs, probably sulfadiazine. Blood cultures became negative and have continued to be so throughout the following year and a half of observation, and clinically the patient appears to have been completely cured of brucellosis.

Reports by Pulaski and Amspacher and by Spink *et al.* appear to confirm essentially the deductions of Eisele and McCullough in their own studies over a shorter period. Thus it would seem rational to employ both sulfadiazine and streptomycin simultaneously in instances of persistent and refractory brucellosis, bearing in mind, however, that each of these drugs may produce manifestations of toxicity, especially when used in maximal dosages.—A. L. TATUM, M. D.

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As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

The Practicing Physician and the Health Department*

Practicing physicians are often confused as to what is meant by the terms "public health" and "preventive medicine." These two terms are often used interchangeably; yet they are actually entirely separate entities. They are, however, very closely allied and almost inseparable. Each has the same goal, better health for the people living in the community, although they arrive at that goal by different paths.

Preventive medicine might be defined as the application of medical technics to the individual by a physician for the prevention of disease or promotion of health. Public health, however, is a broader term. The often-repeated definition of Winslow is difficult to improve upon, that is, that "Public health is the art and science of preventing disease, prolonging life and promoting physical and mental efficiency through organized community effort." It includes such accepted public health functions as the gathering of vital statistics and their analyses; measures aimed at the control of communicable disease; environmental sanitation, including purification of water and sewage disposal; public health laboratory services; maternity, infant, and child health services; and health education. The essential difference between preventive medicine and public health is that preventive medicine is a technic ordinarily applied by a practicing physician to an individual, whereas public health is a technic usually applied by a public health worker to large numbers of people or even to the environment.

Public health programs often include many functions other than the six essential activities just listed. Just how broad is the term "public health"? There is a wide diversity of opinion, even among health officers, as to just what can be included under the scope of public health. To help us decide this question we should define what constitutes a "public health problem" and analyze each activity in the light of that definition.

A public health problem has been defined as (1) any disease or condition that is a widespread cause or potential cause of morbidity or mortality, (2) relative to which there is scientific knowledge which if applied would prevent, cure, or ameliorate, and (3) which requires an organized community effort for its solution.

Applying this definition, let us select a few public health programs as practiced in the United States and see whether they meet these criteria: The sanitation of public water supplies is one example. Typhoid fever and other water-borne infections constitute a constant potential cause of morbidity and mortality in any municipality where the water supplies are not properly sanitated. We have the knowledge of methods which can safeguard our municipal water supplies, and community organization is required to bring about the use of this knowledge; therefore this program meets clearly all three of the criteria for a public health problem.

Let us take another example, such as immunization for diphtheria and smallpox. Here we can readily see that we meet the first two criteria but may or may not meet the third. Diphtheria and smallpox are, without question, potential causes of morbidity and mortality. We know how to prevent through immunization; yet whether community organization is needed to bring about immunization is dependent upon whether or not the service has been provided by the private physician. If the practicing physician has accepted the responsibility of immunizing each baby he delivers before the child reaches 1 year of age, then the health department could drop immunization from its program, as it would no longer constitute a public health problem; however, as long as universal immunization is not practiced by the practicing physician and large portions of the population are non-immune, the health department has an obligation to protect the community through the use of mass immunization.

The logic of a health department is clearcut. Diphtheria and smallpox are prevalent in the community or are at least a potential menace. An effective method of prevention is at hand; through well recognized channels of mass education and appeal the community can be advised of the facts. The health department cannot side-step the responsibility for protecting the community against potential epidemics.

There are numerous other examples of public health problems, such as tuberculosis, cancer, venereal disease, mental disease, heart disease, diabetes, malnutrition, and many others which can be analyzed by this same method.

In some public health programs the question arises as to what extent the health department physicians shall participate in clinical work. We believe that, as a fundamental principle, the health department should do as little clinical work as possible compatible with the protection of the general health of the community. In the few instances when it has been impractical to have the clinical work

*The theme of this paper was presented at the Secretaries' Conferences of the State Medical Society held at Fond du Lac, Baraboo, Wausau, and Rice Lake on May 26 and 27 and June 2 and 3, 1948.

done by the practicing physician, arrangements have been made with the practicing physician on a fee or part-time employment basis. We recognize, however, that all measures for the promotion of the health of the individual are essentially the function of the private practitioner of medicine and that health departments should do everything in their power to work toward that ideal.

Many of the diseases that constitute public health problems could be solved if the person suffering with the diseases would go to his physician for treatment. Here the health department plays its major role, that of health educator, pointing out the advantages of early and adequate medical care. In some instances in which the person may not know of his disease, the health department serves by conducting a case-finding program, screening of apparently healthy individuals and by epidemiologic investigation. Let me emphasize again that the major role of every health worker is health education.

The paths of the practicing physician and the health department cross frequently; they are both working for the same goal, better health in the community; there is much that each can do for the other, and cooperation and understanding are essential. When the health officer sees the viewpoint of the practicing physician and the physician understands the purposes and objectives of the health department, each will reap rich rewards in the accomplishment of community health.

Public health administration in the United States is still in a developmental stage. It should be thought of as dynamic rather than static, as changes in procedure must be made continuously in order to take advantage of scientific progress. Methods which are found to be unsatisfactory or unworkable should be discontinued. Research is essential to progress in public health.

Since 1942 there has been a great deal of study by the keenest minds in public health administration on the most effective means of obtaining a complete coverage of the nation with efficient and economical local health services. The result of these deliberations was the recommendation that local health departments covering a population of not less than 50,000 be organized to blanket the country. Each local health department would have a full time physician trained in public health as its health officer, a sanitary engineer and assistant, and one public health nurse for each 5,000 persons in the community.

The county is recognized as the most practical, efficient, and economical unit of government to provide the basic health services. This, of course, assumes that there will be a minimum population of 50,000. Where the population is less than this, it would be necessary to form multiple county or city-county health departments. The state would act primarily as an advisory agency providing consultation in public health specialties rather than direct local services. The local health department would be supported largely from local tax sources and would be governed by a local board of health.

These decisions were based upon certain well known axioms; first, that direct services of a health department must emanate from the smallest possible unit of government that is consistent with economy and efficiency, as the smaller the unit in area and population, the closer the contact with those who benefit by the service. Second, public health succeeds or fails according to the extent that it succeeds in reaching the people and in educating them concerning its aims, its purposes and its methods of procedure. Lastly, public health fails unless people feel that the services are an essential part of their lives to which they contribute and for which they are responsible.

This trend in local health administration has been recognized and approved by the American Public Health Association and the American Medical Association as well as by your own State Medical Society. In 1947 enabling legislation was passed in Wisconsin making possible the organization of county, city-county, and multiple county local health departments.

At the present time perhaps the two greatest remaining obstacles to the development of local health departments are (1) lack of balanced financial support and (2) a lack of local interest. It may be necessary, at least in certain counties in the state, to provide federal or state subsidies before local health departments can be organized. It is estimated that the cost of a unit to provide the six basic public health functions would be approximately $1.50 per capita.

Interest in the public health of a community can be stimulated by the organization of local public health councils made up of citizen groups to study the health needs of the community. With this in mind, the State Board of Health recently encouraged the organization of a state-wide public health council, which it was hoped would form the nucleus for the organization of local county councils. Should this organization develop, as we hope it shall, each county will eventually have its own public health council, with the objective of studying the community health needs. It is believed that the county public health council, upon studying the public health needs of the community, will arrive at much the same conclusions as the leaders in public health have throughout the country; and that is the need for the organization of a full-time local health department that will serve the entire community, rural as well as urban.

The trend in public health administration in Wisconsin can then be said to be in keeping with good democratic government. It is a movement to build strong, autonomous, self-governed local health departments which can provide efficient, economical down-to-earth, grass-roots public health services.—Carl N. Neupert, M. D., *State Health Officer*, and E. H. Jorris, M. D., *Assistant State Health Officer.*

The
MEDICAL FORUM

The Wisconsin Medical Journal — August, 1948

ESTABLISH WISCONSIN PUBLIC HEALTH COUNCIL

EDITORIAL COMMENT

The following editorial is reprinted from the "On, Wisconsin" column of *The Milwaukee Journal* of July 27, 1948. It aptly sums up the challenge facing medicine and others in the formation of health councils.

"STATE HEALTH COUNCIL IS SET UP; IMPORTANT TASK AHEAD"

The recent formation of the Wisconsin Public Health council is a forward step in co-ordinating the efforts of many agencies, public and private, which can help protect and improve the health of the people of this state. The state council can be very helpful, too, in setting up county health councils. And that should assist in putting the whole public health campaign on more of a "grass roots" basis than it has ever been in this state.

It will be a little startling to some readers to learn that two-thirds of the population of our state do not even have the protection of a full time health officer. A very high percentage of the health officers in Wisconsin have had no professional training in medicine or sanitation or any subject related to public health.

Great has been the progress in discovering the ways in which disease can be prevented or detected for early treatment, and how stronger bodies can be built. But Wisconsin residents still are not getting more than a fraction of the benefit of such scientific knowledge.

That is why creation of the new state council on public health is important. Lay organizations, and specialized health organizations, and professional organizations have joined forces. This should mean that there is a central driving force to see that public health measures are promoted.

It will take dynamic leadership, diplomacy and determination. Public apathy will have to be conquered. The stiff necked attitude of some professional groups will have to be broken down. There will be other serious obstacles to be overcome. But all this has been done elsewhere and should be entirely possible in Wisconsin.

The results, in terms of better health for more of our people, should justify the effort and cost.

ON THE INSIDE

	Page
Narcotics	5
Public Relations	8
Veterans	6
Wisconsin Physicians	4
Wisconsin Plan	7
Wisconsin Press	2

Richard Bardwell.

Doctors Asked to Return Dangerous Drug

Chicago, July 30.—Doctors and druggists were urged today by the Federal Security Agency's food and drug administration to return all stocks of "Siliform Ampuls" to the manufacturer, The Heilkraft Medical Co., Boston, Mass.

This injection drug, which should be sterile, is potentially dangerous since samples collected on the market contain living organisms.

The food and drug administration found the contaminated samples after an inspection disclosed that the ampuls had been manufactured without sterilization. Two weeks of intensive efforts have failed to bring in all of the stocks.

Will Honor Laymen for Contributions to Medical Progress

A citation for distinguished service will be awarded annually at future AMA conventions to one or more laymen who have contributed most to the advancement of American medicine, as the result of a resolution introduced by Dr. William Weston, Columbia, South Carolina, and passed by the House of Delegates.

Challenging Opportunity for Real Action to Solve Health Problems

Madison, July 15.—The Wisconsin Public Health Council was created on July 15, 1948 as the first step toward integrating the many forces at work in the health field in the state in order to better promote and protect the public health.

President of the new Council is Mr. Richard Bardwell, director of the Madison Vocational School. Other officers are William J. Deegan, Superior, 1st vice-president; Mrs. Oliver Plantinga, Rothschild, 2nd vice-president, and Mrs. A. W. Hammond, Beaver Dam, treasurer.

Dr. W. D. Stovall and Mr. C. H. Crownhart of the State Medical Society are members of the board of directors. Others are Mr. T. A. Duckworth, Wausau; Mr. Palmer Daugs, Lake Mills; Miss Susan Normann, Waukesha, and Mrs. Donald Shepard, Neenah.

The new Council will have many functions. An immediate goal is publicizing the need and purpose of county or area health councils composed of representatives of professional groups such as medical, dental and nursing groups; official and voluntary health agencies such as the PTA, Chamber of Commerce and the Farm Bureau; and any other outstanding citizens who can be helpful in meeting health needs.

Explaining the State Medical Society's role in this movement, Dr. Stovall said, "The people of Wisconsin can expect full cooperation from the doctors of the state in planning and developing programs to improve the health of our people."

Dr. C. N. Neupert, state health officer, declared that the Council should make every effort to promote the establishment of full time city, county or city-county health departments as the means to im-

(Continued on page 3)

COMMENTS FROM THE WISCONSIN PRESS

The *Milwaukee Sentinel* of July 14, 1948, carried an editorial and cartoon pointing out what would happen if the British ventures into socialized medicine were transplanted to the United States. Both are reprinted here with the permission of the *Sentinel.*

"UNBOUNDED BUREAUCRACY"

The Dukes of Devonshire and the Earls of Derby, along with their tradesmen, employes and retainers, may now obtain 'free' medical treatment in Great Britain.

The Socialist Labor government has put into effect its national Health Service Act, establishing 'socialized medicine.'

The act not only compels almost every doctor and dentist in England and Wales to become a public lackey, subject to bureaucratic regulation, but also 'entitles' every person to the 'benefits' of the service, and taxes them whether they 'accept' or not.

So the service is not 'free' at all, in any sense of the word.

The Health Act is one of four 'social security' measures which comprise jointly the 'Welfare Plan' originated by Lord Beveridge, otherwise known as the 'cradle to the grave' scheme.

This British venture into extreme Socialism is of interest to Americans because attempts have been made to introduce the Beveridge plan into this country, AND THESE ATTEMPTS MAY BE EXPECTED TO BE RENEWED.

In 1945 New Deal senators and representatives presented in Congress two bills—socalled Full Employment Bill and a General Welfare Bill—which, with other Socialistic proposals, were a full replica of the Beveridge plan.

All of this legislation was rejected in Congress, a rather mild substitute for the Full Employment Bill being enacted.

When and if the same proposals are brought up again, the American Congress and the American people will need to consider that socialized medicine has not worked well anywhere in the world.

They will need to decide whether or not to give up the best medical and hospital service ever developed in order to obtain something very inferior.

They will also need to estimate the financial costs of totalitarian collectivism and its obvious effects upon individual liberty and upon a people's standard of living.

England already provides some data.

The British Health Service is to cost 250,000,000 pounds a year—roughly the equivalent of a billion dollars—all to be paid out of taxes.

Since the National Health Service Act is not sufficient in itself for Socialistic purposes, it is accompanied by a National Insurance Act, more extensively devised than our present Social Security Act, which is to cost another 511,000,000 pounds—or more than two billion dollars—in 1948, this cost rising progressively to 788,000,000 pounds, or more than three billion dollars annually, within thirty years.

British workmen will pay a compulsory rate of about one dollar a month for their industrial and old age insurance, plus contributions by employers.

Deficits will of course be met out of taxation.

To complete the set up, workmen's compensation is taken out of the hands of private experienced companies and is made a bureaucratic function.

The fact is important that anything like the whole British plan will cost the American people many billions of dollars a year—far beyond the British costs by reason of our larger population and higher expenditure scales.

More important is the fact that, with virtually every man, woman and child compelled to become a dependent upon the government, A BUREAUCRACY ACTUALLY INCOMPUTABLE IN SIZE WILL BE ERECTED, and, once erected, SUCH A BUREAUCRACY CAN PROBABLY NEVER BE DISPLACED.

HEALTH COUNCIL—

(Continued from page 1)

proving community health and forming the backbone of adequate laboratory, sanitation, public health nursing and other health services.

Officers of the new group envision the Council as a guiding and encouraging hand for local groups who desire to establish much-needed county health councils. Any county public health council may become a member of the Wisconsin Public Health Council so long as its objectives are consistent with those of the state council.

The Council pointed out the vast opportunities for local community organization of health councils in Wisconsin. Dane county has a health council which does not include the city of Madison. La Crosse has a city-county council. Wausau has a city council, but does not include Marathon county. Other areas have shown an interest—Dunn, Eau Claire, Ozaukee, Pepin and Sheboygan counties.

Actually none of the existing councils in Wisconsin have combined all the forces available for concerted action to promote public health in every phase. According to Council officers, this is the major function of county councils. They can provide a means of integrating the existing agencies and eliminating duplication of effort. They can survey their own local and area health problems and discover the best local solutions.

At the executive committee meeting of the State council on July 15 committees were appointed to handle various phases of the organizational work. They include Mr. Harold Kautzer, Madison, membership; Mr. Harold Link, Kaukauna, program; Mr. T. A. Duckworth, Wausau, constitution and by-laws; Mrs. Robert Kieckhefer, Brookfield, publications and education, and Mrs. Oliver Plantinga, Rothschild, public relations.

Taussig–Blalock Get $5,000 Passano Award

Dr. Helen B. Taussig, associate professor of pediatrics, and Dr. Alfred Blalock, professor of surgery, at Johns Hopkins University School of Medicine in Baltimore, were awarded the 1948 Passano Foundation Award for advancement in medical research. Presentation of the $5,000 cash award was made by Dr. Morris Fishbein.

Study Enrolling Agency for Blue Cross-Shield

Will Submit Plans to AMA

Chicago, July 1.—A proposal to establish a national service agency for enrolling "national accounts" is still being studied by the Blue Shield and Blue Cross commissions.

A "national account," which has become a serious problem for many prepayment plans throughout the nation, is defined as any firm whose employees are spread over an area served by more than one plan.

The enrollment of these accounts has been handicapped for several years by variations among plans in benefits offered, subscription rates, administrative regulations, and the lack of an effective national agency to conduct negotiations.

The proposed agency has been considered for several months. When final agreement has been reached by the Blue Shield and Blue Cross commissions, the complete proposal will be submitted to all Blue Shield and Blue Cross plans, the AMA Council on Medical Service and the proper body of the American Hospital Association.

Seek to Integrate Industrial Medical Care and Civil Defense

Chicago, July 15.—The integration of industrial medical services and community and national defense programs was discussed at a recent meeting of members of the AMA Councils on Industrial Health and National Emergency Medical Service with representatives of the armed forces and government health agencies.

Consulting on the conference were Drs. Carl Peterson, Chicago, and A. J. Lanza, New York, on industrial health, and Drs. James C. Sargent, Milwaukee, and Richard Meiling, Columbus, O., on emergency medical service.

Success of an industrial health program, now recognized as a vital factor in civil defense, would depend largely upon complete coordination of military and civil work in this field, the consultants reported. This involves a vast research program, now partially completed, to determine what supplies and personnel would be needed and just how much is available.

Film Catalogue Available Free for Use by Doctors

Topeka, Kansas, July 15.—A comprehensive catalogue of surgical, medical and dental films, alphabetized by title and classification, has been prepared by the Academy-International of Medicine and may be obtained free by writing that organization. Copies will be provided until the supply is exhausted.

SMS Has Copies

Address requests to Academy-International of Medicine, Department of Audio-Visual Aids, 214 West Sixth Street, Topeka, Kansas.

The State Medical Society of Wisconsin, at Madison, has several copies which will be loaned to physicians upon request.

YOU ARE 100 YEARS OLD BUT ONCE

Wisconsin is making the most of its first 100 years of Statehood—giving recognition to its sons and daughters, its industries and professions—all of the things that have made Wisconsin a great State.

The practice of medicine in Wisconsin has more than kept pace with the rest of the world. The medical profession, together with the economic standards of Wisconsin, has made Wisconsin a healthy place to live.

Our business brings us in close contact with the medical practitioners of Wisconsin, and to this profession may we convey our thanks for your part in developing this great State during its first 100 years.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

WISCONSIN PHYSICIANS SERVICE IS THE BLUE SHIELD PLAN—The Blue Shield shown above is the symbol of the service-type nonprofit medical care plans approved by Associated Medical Care Plans (AMCP). In Wisconsin this Blue Shield represents the doctor-sponsored and operated Wisconsin Physicians Service.

Wisconsin Physicians Service was established in 1946 and in 1947 entered an agreement with Blue Cross which is enrolling and billing agent for the plan. The above poster has been distributed to subscribers, hospitals, and doctors. Wherever these symbols are seen together you know that the Blue Shield represents Wisconsin Physicians Service, the doctor's medical care plan; and Blue Cross represents the hospital care plan.

REPORT HIGH RATE OF HOSPITAL CARE OF MENTAL AND CHRONIC CASES

Washington, D. C., July 10.—Wisconsin had more than 15,000 resident patients in hospitals for the mentally ill at the end of 1946, the Federal Security Agency announced recently.

The hospitalization of mentally ill in the state was 463 per 100,000 population, according to the report. The average for the nation was 372 per 100,000, and varied considerably from state to state.

These differences reflect to some extent the amount of mental illness in each state, but most likely point up the differences in the extent of facilities available, rate of turnover in hospitals, and administrative factors, the report stated.

In Wisconsin, many aged infirm and chronically ill are sent to hospitals for the mentally ill for lack of proper institutions or infirmaries to which they should be sent. The exact number of these persons committed as insane is not known.

The State Department of Public Welfare reports that there are about 65,000 persons in Wisconsin over 25 years of age who are invalided or enfeebled to the extent that they must be cared for by someone and that as many as 12,000 now require care in an infirmary or other similar facility. The department also estimates that there are currently 44,000 persons aged 65 years or older who can be classed as aged infirm and at least 9,000 immediately need infirmary care.

Be Familiar With WPS Benefits, Director Asks

Keep Secretary Posted, Too

Madison, July 30.—Do you know that the patient's failure to identify himself as a member of Wisconsin Physicians Service may cost him some benefits, asks Ralph F. Weber, director of Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society.

Physicians or their secretaries can eliminate this difficulty and the poor public relations it involves by being familiar with WPS benefits, and by asking each patient if he or she is a member of any prepayment plan, he said. This is particularly true of the doctor's secretary because she is the first to meet the patient and she handles much of the detailed work on forms and blanks.

Since WPS is the doctor-sponsored and operated non-profit service plan of the State Medical Society, Mr. Weber emphasized the importance of the doctor's knowing the details of its operation.

Here is a checklist of important things to know about WPS, the Blue Shield Plan:

1. Be familiar with the entire plan and its benefits.
2. Know how to handle the Physician's Service Report Form.
3. Be familiar with the income levels and full coverage features.
4. Know what services are provided in the hospital.
5. Know about x-ray services in the doctor's office.

And tell your secretary about these things, Mr. Weber suggests. See that she gets and reads the WPS folders, leaflets and literature. If she has the necessary WPS fee schedule and blanks and if thoroughly familiar with the plan, he added, she will understand the service the doctors are trying to perform through WPS and can be a great aid in developing the plan.

Consumers Hit Bottom of Their Savings Barrel

Shift in Buying Power

New York, July 3.—Recent economic trends having considerable significance for medicine generally and for prepaid medical care plans in particular, are reported by Prentice–Hall, Inc., recognized for their analyses and studies of legal and economic matters.

Their report points out that the rapid exhaustion of savings among lower income groups has caused a shift in buying power. "About one-quarter of all U.S. spending units spent more in 1947 than they earned," the report said.

Prentice–Hall states that this trend is accelerating as higher prices force consumers to dig into savings and resort to credit to buy the things they want. "Thus, despite the government's recent bond selling campaign, more Series E bonds are being cashed than bought. Similarly, turning in of life insurance policies for their cash surrender value has jumped to a record high."

Real buying power is shifting back toward the higher income groups which, before the war, were the main spenders for durable goods and higher priced luxuries," according to the report. The major market for such goods is now the 14% of the population with cash incomes of $5,000 per year and over. This group accounts for 40% of total U.S. money income before taxes, and probably controls more than half of the real buying power of the country, Prentice–Hall says.

The Federal Reserve Survey shows that this group includes employers, professional and other self-employed persons, managerial employees, and top fringe skilled workers. About 40% of the professional people are in the $5,000 and up group; about 45% of the managerial and self-employed persons; and about 8% of skilled and semi-skilled workers.

Prentice–Hall declares that the Federal Reserve survey "greatly underestimates" the buying power of the U.S. farmers. "It shows three-fourths of the farm consumer units with money incomes of less than $2,000, and about one-third with money incomes of $1,000 or less. Actually, the buying power of farmers is much higher than these figures suggest."

Interns and Residents Learn About Rural Practice at Meeting

Kansas City, July 1.—Introducing interns and residents to the advantages of rural medical practice is a project adopted by the committee on rural medical service of the Missouri State Medical association.

Recently a panel meeting was held in Kansas City with four young rural physicians answering the questions of more than 100 interns and residents who attended. The rural practitioners, from towns of 600, 1,800, 3,200 and 6,100 population and varying degrees of facilities, answered every question from their personal experience in rural practice.

Sargent and Bortz Are Medical Advisors to Security Resources Board

Washington, D. C., July 29.—A medical advisory committee to consult with the National Security Resources Board on Security aspects of public health has been named by Arthur M. Hill, chairman of the Board.

Dr. James C. Sargent, Milwaukee, chairman of the permanent AMA Council on National Emergency Medical Service, which deals with the doctor's interests in problems of national emergency, was named a member of the committee.

Other members are Dr. Edward L. Bortz, Philadelphia, immediate past president of the AMA; Dr. William P. Shepard, San Francisco, of Metropolitan Life Insurance Co.; Dr. A. C. Bachmeyer, Chicago, director of the hospital at the University of Chicago and former head of the Commission on Hospital Care; Dr. Michael E. DeBakey, New Orleans, assistant professor of surgery at Louisiana State University, and Dr. Percy T. Phillips, New York, secretary of the New York Dental Society.

The newly formed committee will hold its first meeting sometime in August. It will work in cooperation with Dr. James A. Crabtree, director of the Medical Services Division of the National Security Resources Board.

NARCOTIC AGENT ISSUES WARNING

Asks Cooperation With Police

Madison, Wis., July 28.—A plea and a warning have been issued to the medical profession by Mr. Owen W. Lewis, Madison, agent for the Treasury Department Bureau of Narcotics.

Mr. Lewis urgently requested that doctors cooperate with law enforcement bodies by notifying the sheriff's office or the police department when a transient addict comes to their offices in order that they may check on such an individual, rather than wait until a doctor's office or automobile is prowled or burglarized for the purpose of obtaining narcotics.

He warned physicians that they must not use prescriptions to obtain narcotic drugs for their office use. A prescription written for narcotics in the name of an individual must be for the use of that individual only, and narcotics for general practice must be obtained on government official order form.

Mr. Lewis also announced that Mr. R. W. Artis, Bureau of Narcotics, 817 New Post Office Building, Chicago 7, Illinois, is the present District Supervisor for the district including Illinois, Indiana and Wisconsin.

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References furnished on request.

VA Sets Up Standards to Select Specialists

Usually Need Certification

Chicago, Ill., July 13.—The Veterans Administration has set up standards for the selection of medical specialists to perform out-patient examination or treatment services for veterans.

These standards are for the guidance of branch VA office chiefs when selecting specialists to function under the Wisconsin Veterans Medical Service Agency.

Specialists, excepting neuropsychiatrists designated for therapy, must have certification by the appropriate specialty board in order to be selected for VA work.

Other Qualifications

Specialists not possessing specialty board certificates may be selected for VA work if they have:

1. At least four years' experience in a given specialty including recognized residency, and
2. At least 50% of their practice devoted to a given specialty, and
3. Recognition as a specialist by the medical association or society in the state in which they practice.

Exceptional Cases

Exceptional cases of physicians who do not meet the standards above will be referred for final decision to the central VA office.

County Society Key Organization in Medical Care

The county medical society's responsibility to its membership and the public and its prominent role in medical organization was stressed at the National Conference of County Medical Officers on Sunday, June 20, during the annual AMA meeting.

Because of its close contact with the practicing physician and the community activities, the county society plays the fundamental role in medical organization. Physicians should be encouraged to join their county medical society early in their professional career, but selection and maintenance of membership should be kept at a high ethical level, speakers pointed out.

Industrial Health Men Pay Tribute to James

Was Pioneer in Factory Health and Safety

"Probably the greatest friend medicine has ever had in the field of industrial health in Wisconsin was in the person of Mr. W. D. James, former president of the James Manufacturing Co., Fort Atkinson," declared Dr. Daniel E. Dorchester, Sturgeon Bay, chairman of the State Medical Society's committee on industrial health, and Dr. Paul A. Brehm, Madison, director of the industrial hygiene unit of the State Board of Health.

Mr. James died on April 16, 1948. He was one of the state's most prominent industrialists, and a former regent of the University of Wisconsin.

W. D. James.

The tribute paid him by the medical society and the board of health in recognition of his outstanding work in the furtherance of better health and safety for industrial workers is exemplified in the statement of Dr. Dorchester:

"Mr. James played a prominent role in support of the society's committee on industrial health from the day of its inception in June, 1939. He was among the first to practice what was 'preached' about industrial health services. He was concerned with the health of the worker as an individual in the community as well as on the job in a plant.

"Not only did Mr. James build up an exemplary record of industrial health and safety in his own factory, but he used his membership in the Wisconsin Manufacturer's Association to advocate safety and welfare of the employee in all the manufacturing plants of Wisconsin."

Dr. Brehm stated that it was "unusual for a layman to have educated himself so thoroughly in industrial medical affairs and carried out his knowledge to benefit both his own plant and hundreds of others." Mr. James was particularly instrumental in placing industrial health programs into operation in the small industrial plants of the state.

AMA OFFICERS FLY TO JAPAN TO STUDY SICKNESS INSURANCE

Invited by MacArthur

Chicago, July 30.—At the invitation of General MacArthur, five officers of the American Medical Association left on August 1 for Tokyo, where they will confer with a group of medical consultants on various phases of the proposed Japanese Social Security System, including sickness insurance.

The AMA group included President R. L. Sensenich; President-Elect Ernest E. Irons; Dr. Elmer L. Henderson, chairman of the Board of Trustees, and Drs. E. J. McCormick and John H. Fitzgibbon, members of the Board.

Challenge Motives

On July 24, Secretary of the Army Kenneth C. Royall made public the Japanese health and welfare report originally submitted to Gen. MacArthur by a group of experts whose motives have been repeatedly challenged by Rep. Forest A. Harness investigating propaganda activities of the executive branch of the government.

Aimed at Socializing

Rep. Harness has charged that the group which made the report to MacArthur was primarily directed by the Social Security Administration to spread "socialized medicine." The one doctor in the group who made the report was Dr. Joseph W. Mountin of the U. S. Public Health Service.

The report recommends strengthening and expanding Japan's national health insurance system and allocation of greater public funds for construction and maintenance of hospitals.

ANOTHER FLYING DOCTOR . . . Dr. A. W. Hankwitz, Milwaukee, recently used his plane to return a patient to his home after a long period of hospitalization. Dr. Hankwitz, (right), flew patient Frank Beaudry, Appleton, (stepping out of plane), from Billy Mitchell field in Milwaukee to the Outagamie County airport which is within 100 feet of Beaudry's house.

Wisconsin Plan Reports Progress

Madison, Aug. 6.—Complete statistical reports are being compiled by the private insurance carriers which sell the State Medical Society approved Wisconsin Plan of Surgical, Obstetrical and Hospital Care, it has been announced.

These reports will provide latest information on coverage, premium income, and benefits paid by the Wisconsin Plan companies. The statistics are being assembled by Mr. Billedward Howland, Health and Accident Underwriters Conference, Chicago.

Bill by New Plan

New schedules of benefits for The Wisconsin Plan went into effect on May 31. This schedule applies for all policies effective after May 31. Policies which were in effect prior to this date will continue to be billed under the old schedule of benefits until the anniversary date of the policy.

Doctors are advised to bill all Wisconsin Plan patients under the new schedule, and differences can be adjusted between insurance companies and doctors if the need arises. The Wisconsin Plan committee, headed by Dr. H. H. Christofferson, Colby, will aid in this situation if necessary.

TOMAH VA STARTS RESIDENCY CLASSES

Madison, Aug. 2.—The Veterans Administration is organizing a new class of residents in psychiatry for training in the recently completed VA hospital in Tomah, Wis., under supervision of the dean's committee of the University of Wisconsin Medical School headed by Dr. William F. Lorenz. The class is expected to be ready by Sept. 1.

Residents in the Tomah hospital will rotate between the university's psychiatric institute in Madison and the hospital on a six month's basis. Time in school will be devoted to clinical services under the department of neurology and psychiatry. The residents also will give part time to the Madison VA outpatient clinic for neuropsychiatric patients. School work will be directed by outstanding specialists.

The first year of residency will be devoted to basic science instruction in neuroanatomy, neurophysiology and psychobiology. The second year will be given to neuropathology, psychopathology and clinical assignments in the department of psychiatry.

The Tomah hospital accommodates 1,200 patients and provides opportunity for clinical experience over a wide range of neuropsychiatric disorders.

Three grades of residents have been established: senior, $3,000 a year; intermediate, $2,700 and junior, $2,400. Applicants should send a complete biographical sketch and detailed information on medical experience to Dr. Lorenz, University of Wisconsin Medical School, 1300 University Ave., Madison. A personal interview can be arranged.

MAY STILL TRY TO DRAFT PHYSICIANS

Consider Two Methods

Washington, D. C., July 26—A movement to amend the Selective Service Act so as to make physicians and dentists inductable may get underway in the special session of Congress called by President Truman, according to Charles G. Gross, editor of the *Washington Report on Medical Sciences.*

He reports that many conferences have been held on the military medical departments' personnel shortage since the doctor draft was rejected when the Selective Service Act was first passed. There was discussion of the increased medical and hospital care burden which is coming as a result of induction of draftees and the possible event of a national emergency.

Mr. Gross reports that two solutions are being considered. The first is to restore the clause, previously rejected by Congress, by which doctors up to the age of 45 could be inducted. The other possibility is a modified doctor draft limited to those who receive all or part of their professional education at government expense.

The Judge Advocate General's office has handed down legal opinions stating that the government has no real strings on former ASTP and V–12 men even though they were deferred from World War II while they got their medical training. The opinions stated only that any or all Army or Navy reservists can be called to active duty at any time. However, neither the Army nor the Navy wishes to invoke that authority. Meanwhile, the Armed Forces are making every effort to build up their medical strength by substitute measures. This includes hiring of civilian physicians on a part-time salary basis, increasing retirement benefits for reserve officers and intensifying their reserve training programs.

Form Permanent Steering Committee on National Health Assembly

Request State Assemblies

Washington, D. C., July 30.—Plans to continue the National Health Assembly steering committee as an "advisory and coordinating group," were announced recently by Federal Security Administrator Oscar Ewing.

Objectives of the committee include stimulation of regional, state and local health conferences patterned after the national assembly with equal representation to professional and "consumer" groups; encouraging all communities to assess their own health needs and solve them by cooperation with the Federal Security agency and other government agencies, and publication of the recommendations of the National Health Assembly and follow-up to see that they are carried out as well as possible.

Dr. George Lull, secretary-manager of the AMA, is a member of the steering committee. Other members are Nelson Cruikshank, director of insurance activities, American Federation of Labor; Graham L. Davis, president, American Hospital Association; Miss Katherine Densford, president, American Nurses' Association; Dr. Vlado Getting, president, Association of State and Territorial Health officers; Mrs. Mary Lasker, Lasker Foundation, New York; Mrs. Eugene Meyer, wife of the publisher of the Washington *Post;* and Jerry Voorhis, general secretary of the Cooperative League of USA.

State Doctors Asked to Michigan Annual Session

Detroit, Aug. 8.—Doctors of medicine from Wisconsin are invited to attend the 1948 Annual Session and Postgraduate Conference of the Michigan State Medical Society at the Book-Cadillac Hotel, September 22-23-24.

The scientific session will feature 31 guest essayists among them Drs. F. H. Lahey, Boston; and Waltman Walters, Rochester.

To insure hotel accommodations for the session write E. C. Texter, M. D., Chairman of Housing Committee, 1005 Stroh Building, Detroit.

PUBLIC RELATIONS IN PRACTICE

Two more radio stations have been added to those carrying the "March of Medicine," the program prepared by the Committee on Health and Public Instruction. They are WBEL, Beloit, presenting the program every Wednesday at 1:45 p.m., and WLDY, Ladysmith, which puts the program on the air each Saturday at 10:15 a.m. This makes a total of 25 stations carrying the public service feature.

-PR-PR-

PR PRIZE OF THE MONTH—goes to the River Falls Clinic. Here is what the St. Croix Falls *Standard Press* has to say about it:

"CLINIC ESTABLISHES NEW PUBLIC SERVICE"

"The River Falls Clinic has established a physicians service which should be valuable as a public service to the citizens of River Falls.

"The idea of the plan is to keep a constant contact between the people and their doctors. In the event that your doctor cannot be reached at his home phone you may call number 200, the office phone, at any hour day or night, and you will be informed of the doctor's whereabouts and how you may contact him. In event that your doctor is not available you may also be informed which of the others are available and how you may contact them.

"The River Falls Clinic should be complimented for this additional effort to public service."

-PR-PR-

The medical men of Wausau have joined the public health nurses, dentists and public and parochial schools in a sweeping program to safeguard the health of Wausau children. Objectives: physical exam with corrective measures taken where needed for every pre-school child entering school in fall; educational programs for mothers and children. Result: good public relations.

-PR-PR-

Good public relations begin at home. Dr. A. H. Heidner, West Bend, provides a most powerful example of this truth. On July 12 he retired from his post on the West Bend school board after 22 years of "loyal, faithful and distinguished service to the cause of education in this city."

The West Bend *News* said: "Dr. Heidner deserves the thanks of every resident of this city, and it was fully appropriate that he was given a rising vote of appreciation at the annual meeting."

The West Bend *Pilot* said: "We owe a great debt of gratitude to Dr. Heidner for the laudable manner in which he has served this community . . . There are few men in this city who have less spare time than have our doctors, and yet this public-spirited doctor has for 22 years given hour after hour of precious time to his duties as a member of the school board."

The Profession can say: "Well done, colleague."

-PR-PR-

From the Public Relations News Letter of the Medical Society of the State of Pennsylvania:

"For those who criticize the activities of your county society by saying — 'What am I getting out of the society? What has the medical society done for me? I pay my dues each year and get nothing in return' — may we suggest the following antidote.

'A horse can't pull while kicking,
This fact I merely mention—
And he can't kick while pulling,
Which is my chief contention.'"

-PR-PR-

Public Relations Convo in St. Louis, Nov. 27

First on Medical PR

Chicago, July 21.—A national medical public relations conference, the first of its kind, will be held in St. Louis on November 27, Dr. George F. Lull, secretary-manager of the AMA, announced recently.

"Shooting at Common Targets in Medical Public Relations" is the theme of the conference, to which will be invited public relations directors, executive secretaries charged with public relations duties and public relations committee chairmen.

A workshop session will grapple with six major issues facing the profession: selling the need of public relations to state medical society members, encouraging wider use of medical prepayment plans, setting up workable systems for handling night calls, the rebate problem, and developing good will.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

S. B. PESSIN

Doctor Pessin, who is associate professor of pathology and bacteriology at Marquette University School of Medicine, is also a graduate of that institution. He served his internship and a residency at Milwaukee County Hospital. A diplomat of the American Board of Pathology, he is director of laboratories at St. Mary's Hospital, Milwaukee.

The "Water Test" in Addison's Disease

Typical Addison's disease, characterized by asthenia, loss of weight, gastrointestinal disturbance, pigmentation, and hypotension, invariably yields the following cardinal laboratory findings: (1) decrease in serum sodium, (2) decrease of serum chlorides, (3) increase of serum potassium, (4) increase of blood urea and nonprotein nitrogen, (5) decrease of plasma volume, and (6) increase of packed erythrocytes.

The so-called subclinical Addison's disease, or adrenal cortical insufficiency, must be suspected in a fairly large group of asthenic patients who are chronically tired and have low blood pressure. The enumerated laboratory findings are usually normal in these patients. Likewise, the laboratory tests may not yield significant results in those patients suffering from Addison's disease who are experiencing a period of fair health.

Within recent years, several functional tests have proved to be valuable diagnostic aids. The best functional tests are the salt deprivation tests of Harrop, Weinstein, Soffer, and Trescher and Cutler, Power, and Wilder. However, these tests may prove hazardous to patients with Addison's disease because they may precipitate a state of crisis (acidosis). The "water test" of Robinson, Power, and Kepler is without deleterious affect on the patient. The test is based on the well known fact that in patients with Addison's disease diuresis does not develop promptly after ingestion of large quantities of water. The test has two procedures. If procedure I, the "water test," is positive, blood and urine chlorides and urea (procedure II) are determined, and all of the results of the two procedures are incorporated and solved by an equation.

Procedure I: The "Water Test".—The day before the test, the patient eats three regular meals without extra salt, and consumes the necessary amount of fluid. No fluids are given after 6 p. m. At 10:30 p. m. the patient is requested to void, and specimen is discarded. All urine voided from then on until and including the 7:30 a. m. voiding is collected, measured, and saved for chemical analysis in case the test proves to be positive. Breakfast is omitted. At 8:30 a. m., the patient is requested to void, and the specimen is discarded. Next, 20 cc. of water per kilogram of body weight (9 cc. per pound) is given. This amount must be consumed within forty-five minutes. Four hourly specimens of urine (9:30, 10:30 and 11:30 a. m. and 12:30 p. m.) are collected in separate containers, and each amount is measured.

Interpretation: If the volume of urine (day specimen) of any single hourly specimen voided after ingestion of water is greater than the total volume voided during the night, the test is negative, indicating absence of Addison's disease. If, however, the largest hourly specimen is less than the volume of the night urine, Addison's disease may or may not be present, and the second part of the test is performed.

Procedure II: Urea and Chlorides of Blood and Night Urine.—While the patient is still fasting, blood is drawn and its plasma is analyzed for urea and chlorides. The night specimen of urine is also analyzed for urea and chlorides. The following equation is then solved.

$$A = \frac{\text{urea in urine (mg.\%)}}{\text{urea in plasma (mg.\%)}} \times \frac{\text{ch'orides in plasma (mg.\%)}}{\text{ch orides in urine (mg.\%)}} \times \frac{\text{volume of day urine (cc.)}}{\text{volume of night urine (cc.)}}$$

Interpretation: If the value of A is greater than 30, the patient probably does not have Addison's disease. If the value of A is less than 25, the patient probably has Addison's disease if nephritis is ruled out.

If the results of procedure II are questionable or if they are negative when there is clinical evidence of Addison's disease, any of the salt deprivation tests may be performed. Such instances are seldom encountered.—S. B. PESSIN, M. D.

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2. Harrop, G. A., Weinstein, A., Soffer, L. J., and Trescher, J. H.: Diagnosis and treatment of Addison's disease, J.A.M.A. 100:1850–1855 (June 10) 1933.
3. Cutler, H. H., Power, M. H., and Wilder, R. M.: Concentration of chloride, sodium and potassium in urine and blood; their diagnostic significance in adrenal insufficiency, J.A.M.A. 111:117–122 (July 9) 1938.

. . . . THE PRESIDENT'S PAGE . . . .

A. M. C. P.

ASSOCIATED Medical Care Plans is the national association of Blue Shield plans. Blue Shield is the insignia used to designate physician service plans for sickness insurance developed by the various state, county, and municipal medical societies; Blue Cross is the corresponding plan used by associated hospitals to provide hospital group insurance.

The association of the Blue Shield plans for the purpose of mutual aid in selling prepaid sickness and hospital insurance to groups was first accomplished through the efforts and with the assistance of the Council on Medical Service and Public Relations of the American Medical Association. Thereby hangs the story of the present controversial discussions concerning the organization of a national insurance company to sell group sickness and hospital insurance on a national scale. The controversy involves the need for such an insurance company and the advisability of it. Many of the state and county societies that are now operating service plans for sickness insurance oppose the amalgamation or integration of the Blue Shield and Blue Cross associations into a new association with power to organize a national insurance company. They say that it is not necessary; that an enrolling and collecting agency to facilitate the requirements of national employers is all that is necessary; that a national insurance company will threaten the autonomy of the various state organizations and interfere with local medical society control.

The proponents of the plan are convinced that Blue Shield and Blue Cross operating as independent and unrelated plans in the various states cannot meet the demands of national employers and will fail to supply the coverage necessary to answer the needs which have prompted the proposal for national compulsory sickness insurance. They propose an association of Blue Shield and Blue Cross to sell national employers both sickness and hospital insurance in one package, to underwrite a fuller coverage in states where the coverage is not as broad as it is in other states, and to organize and sell this kind of insurance in states where no sickness or hospital plan is now being operated. It is their opinion that this offers a method of unifying this insurance throughout the country, and of affording Blue Shield and Blue Cross an opportunity to put into one package sickness and hospital insurance.

They explain that this is not a merger of Blue Shield and Blue Cross but an organization composed of the two; that each organization will retain its control with its own national board of trustees; that local autonomy thus will not be disturbed, especially since the premiums collected will be forwarded to the states in which the employees reside minus the deduction of a handling charge.

On Saturday, June 18, the Council on Medical Service of the American Medical Association called together the officers of Blue Shield and Blue Cross and a group of officers of state medical societies in which physician service plans are in operation to discuss this controversial question. It was apparent from the discussions that the officers of the state societies feel that the Council on Medical Service has allowed this question to slip from its control and that no united opinion can be reached until the Council has assumed its proper place in deliberations on the needs for a national association and the nature and type of such an organization.

The final result was a motion referring the matter back to the Council on Medical Service for an impartial and unprejudiced study and requesting that the Council inform the state medical societies at as early a date as possible and the House of Delegates at the mid-year meeting in St. Louis what its conclusions are.

By this action the die was cast, the Rubicon was crossed; the Council on Medical Service was given the leadership for organized medicine in the further development of voluntary sickness insurance. We expect no equivocation, no issue-straddling, no buck passing. It appears that American medicine has out-planned British medicine in the development of a plan for sickness insurance that even to some of the proponents of compulsory insurance appears to have advantages over the latter. In the terms of the golfers, can we now carry through? Can these fifty-one different physician service plans and hospital plans be coordinated or associated in such a way as to perfect a system of sickness insurance that will offer the same coverage to all employees of any industry regardless of the location of their residency? Is a national insurance company the only means by which this can be accomplished? If not, what shall the nature of this association be?

Let the Council build up no scarecrows. *Fear* must not be the dominant emotion in the approach to this problem. Fear is the devastating emotion that throttled the cerebration of British medicine. They were so frightened at the thought of losing control of patient-physician relation that they actually lost it without making suggestions for a constructive defense. If the business men of this country never invested a dollar because of the fear of losing it, progress would indeed be stopped. If doctors object to any and all moves to perfect a system of sickness insurance because they fear that any move will destroy local autonomy, then we are slaves to local autonomy and progress is brought to a crashing stop.

The prospect of governmentalized medicine is frightening enough, but it should not produce paralyzing fear. It is frightening only because a group of those who advocate it are devotees of a philosophy which we cannot adopt or even tolerate. This fear is realistic for many, but in some instances it is a tool used by propagandists and self-seekers to cloud the issue and mislead the doctors. Fear of losing control of medical education, fear of losing control of hospital practices, fear of losing control of nursing education, fear of losing control of physician-patient relation is a normal reflex reaction of physicians in our country, but it affords no defense; rather it leaves the defenses down.

By main strength and awkwardness the British medical society with verbal clubs has fought off state medicine for years. But, main strength and awkwardness were not enough; exhausted and fatigued and outnumbered they succumbed to the attack. With new ideas and plans that are succeeding everywhere in our country we are carrying the attack into the enemies' zone. We call upon the Council on Medical Service to plan for us our advance further into the enemy territory, and, while there will be casualties, we call upon this Council to offer leadership for courageous planning to meet so-called socialized medicine with Americanized voluntary plans for sickness insurance which will demonstrate the resourcefulness of free people to solve their social problems and at the same time preserve the freedom of their institutions and the individual. Fear has no place in this kind of effort.

W D Stovall

As It Looks From the Wisconsin State Chamber of Commerce

W. J. PETERSEN

As executive secretary of the Wisconsin State Chamber of Commerce, William J. Petersen of Madison directs the broad activities of Wisconsin's principal business organization. As president of the National Association of State Chambers of Commerce in 1946 and 1947, he attained national prominence as an active proponent of the American way of life.

Today Socialism is advancing in all parts of the world. In many countries its most acute stage, Communism, has already been reached. In these countries a police state now prevails and freedom has vanished.

Is it weakness of democracy or the strength of collectivism that makes these gains possible? In my mind, it is neither; rather it is weakness in the will to defend freedom that is the cause.

When our founding fathers created our constitution, they methodically designed an instrument which placed the freedom of the people above the will of the state. Sentence by sentence, section by section, it was drawn to guarantee the subservience of the state to the people.

Basing this instrument on the principle that only the free can be strong, our founding fathers charged each succeeding generation with the responsibility to participate in and defend our democracy.

With this instrument and the Bill of Rights as a guardian, we grew to become the greatest and most prosperous nation in the world.

No, our democracy is not weak, but it is losing ground to collectivism because of the failure of freedom's friends to defend it.

You in the medical profession have been fighting a battle to keep your own field free from the shackles of socialized medicine.

Various segments of business too have been waging similar campaigns to stave off collectivist domination of their life blood. Some phases of business, which a decade or two earlier were in private hands, have now been taken over or are dominated by government.

There is no question that various phases of our democratic economy must be defended by those who have knowledge, understanding, and a stake in that particular field. But is this enough? Is this the full participation in and defense of freedom which the founders of our country contemplated? I believe it is not, and unless we can achieve that full participation, freedom will retreat to an even smaller area than it now holds, and eventually it will be destroyed.

Unfortunately, those great segments of our economy which are deeply convinced of the merits of American democracy are content to wage their own independent battles on their own particular problems. This is precisely the course of action the socializers would have us take. Not facing strong united opposition, they are able step by step to defeat the isolated forces of freedom.

I believe we can meet this challenge of collectivism. We already have the strength in numbers to defeat it decisively.

The Chamber of Commerce movement offers the organization through which all forces of freedom can assemble and take united action against collectivist schemes. In more than a hundred of these chambers throughout the state, the participation of the medical profession is needed and is welcomed. Significant strides can be achieved in stemming the advances of socialism if the medical profession will join hands with businessmen in the over-all effort.

Working side by side with businessmen against the common enemy of collectivism will give added strength to the medical profession in its own campaign against socialized medicine. For unless we can turn the tide of collectivism in all major sectors, the medical profession will, at best, find itself an island in a socialistic economy.

I urge you, therefore, to look upon all collectivist attempts to take over portions of our private enterprise system as part and parcel of one general plan. When one element of our economy is threatened, all friends of freedom must rally to its defense.

The united efforts of business, the medical profession, and other segments of society are urgently needed if our American Way of Life is to preserved.
—WILLIAM J. PETERSEN, *Executive Secretary, Wisconsin State Chamber of Commerce.*

The Interurban Academy of Medicine Invites You To Attend A

CANCER TEACHING CLINIC

Superior, Wisconsin ★ September 15, 1948

Clinic Sponsored by 11th Councilor District, St. Louis County Medical Society, Council on Scientific Work, and the Wisconsin Division of the American Cancer Society

NO REGISTRATION FEE—ONLY MEAL COSTS—PROGRAM FURNISHED THROUGH FUNDS OF THE WISCONSIN DIVISION, AMERICAN CANCER SOCIETY

SCIENTIFIC SESSION AT HOTEL ANDROY, SUPERIOR

10:00–11:00 a. m.: *Laboratory Diagnosis of Carcinoma:* Arthur H. Wells, M. D., director, department of pathology, Saint Luke's Hospital, Duluth

11:00–12:00 a. m.: *Carcinoma of the Genito-Urinary Tract:* James C. Sargent, M. D., clinical professor and director of the division of urology, Marquette University School of Medicine, Milwaukee

12:30– 1:30 p. m.: Luncheon: Hotel Androy

2:00– 3:00 p. m.: *Diagnosis and Treatment of Carcinoma of the Breast:* Stuart W. Harrington, M. D., chief of the surgical section, Mayo Clinic, Rochester

3:00– 3:15 p. m.: Recess

3:15– 4:15 p. m.: *Carcinoma of the Colon and Rectum:* Walter A. Fansler, M. D., clinical professor of surgery, University of Minnesota Medical School, Minneapolis

4:15– 5:15 p. m.: General symposium and question and answer period

DINNER MEETING, HOTEL SUPERIOR

6:30 p. m.: Dinner: Hotel Superior
Diagnosis and Treatment of Carcinoma of the Lung: Thomas J. Kinsella, M. D., Minneapolis

DETACH AND MAIL IN ENVELOPE—ENCLOSE CHECK

Luncheon and Dinner Reservation

DETACH AND MAIL TODAY
Make Check Payable to
State Medical Society of Wisconsin

W. S. BUMP, M. D., Chairman, Committee on Cancer
917 Tenney Bldg., Madison 3, Wis.

Dear Doctor Bump:

Attached is a check of $_____ to cover my reservation for the Cancer Clinic to be held in Superior on Wednesday, September 15.

I will attend: The Luncheon ($2.00) at Hotel Androy _____

The Dinner ($3.00) at Hotel Superior . _____

(CHECK MEAL FUNCTIONS YOU WILL ATTEND, PLEASE)

Signed _____
(Please Print)

Address _____

_____

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« « « EDITORIAL » » »

WITH the development of voluntary sickness and hospital insurance programs, the activities of organized medicine have been expanded greatly. Physicians have been cast into the troubled waters of medical economics, and the experience has been a challenge to the entire profession.

But the central core of medical activity still remains scientific in character. The surging progress of medical science demands alert attention of the practitioner who is sincere in his desire to serve his patients and his community. For this reason the State Medical Society of Wisconsin has intensified rather than relaxed its services in the field of scientific medicine, even though problems of medical economics have placed new demands upon the physicians of the state.

It is with pride that the Council on Scientific Work announces the scientific programs for the 1948 Annual Meeting. The Annual Meeting is in many ways the culmination of all scientific activities of the State Society. It brings to the membership outstanding teachers from all parts of the country. It highlights new developments and new discoveries. And through it all there is a spirit of good fellowship which makes attendance at an Annual Meeting far more than a stimulating experience in the acquisition of knowledge.

In this issue of the *Journal* is presented the framework of the scientific programs. Special attention is directed to the clinical conferences which will be held in three Milwaukee hospitals on the opening morning of the Annual Meeting. These conferences will provide clinical teaching with patients which will offer a change from the didactic lectures of other sessions. These clinical conferences are being offered as an experiment, and it is hoped that a number of members will take advantage of this feature of the 1948 Annual Meeting.

The entire three days of meetings offer members of the State Society an unusually fine opportunity of keeping abreast with the latest research and findings in all fields of medicine. Efforts have been made to key all programs to the needs of the general practitioner, so that his understanding of specialized procedures will assist him in his daily practice.

Remember the dates: October 4-5-6. Inform your patients that these days are being set aside so that the benefits of medical progress can be brought to them through you, their family physician.

for YOUR FILES

C. H. CROWNHART
Secretary

ROY T. RAGATZ
Assistant Secretary

STATE MEDICAL SOCIETY OF WISCONSIN
917 Tenney Building
MADISON 3, WISCONSIN

Dear Doctor:

On the following pages you will find a summary of the scientific programs to be presented in connection with our 107th Anniversary Meeting, which will be held in Milwaukee on October 4–5–6.

Special attention is directed to the round tables and the annual dinner, for which advance reservations are suggested, as attendance at these functions is limited. If you have not already done so, kindly fill out the reservation sheet in this section of the *Journal* and return it to our office *immediately*. As many luncheons are already filled or nearly so, be sure to specify three choices in order of preference for each of the days you will be in attendance at the meeting.

Delegates are reminded that the first session of the House convenes on Sunday afternoon, October 3, and hotel reservations should be made accordingly. The official headquarters will be at the Hotel Schroeder, Milwaukee.

Sincerely yours,

C. H. Crownhart

Secretary

Annual Meeting Timetable

★ SUNDAY, OCTOBER 3 ★

p. m.
1:30 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder

★ MONDAY, OCTOBER 4 ★

a. m.
7:30 Registration: Main Arena, Milwaukee Auditorium
9:00 Clinical Conferences: Milwaukee Children's Hospital
Milwaukee County Hospital
Veterans Hospital, Wood

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
6:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
8:30 Informal Smoker and Entertainment: Crystal Ballroom, Hotel Schroeder

★ TUESDAY, OCTOBER 5 ★

a. m.
9:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
5:30 President's Reception for those attending Annual Dinner: Banquet Room, Fifth Floor, Hotel Schroeder
6:45 Annual Dinner: Crystal Ballroom, Hotel Schroeder

★ WEDNESDAY, OCTOBER 6 ★

a. m.
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 Section Meetings: Milwaukee Auditorium
General Practice: Engelmann Hall
Internal Medicine: Plankinton Hall
Obstetrics & Gynecology: South Juneau Hall
Ophthalmology & Otolaryngology: North Juneau Hall
Pediatrics: North Kilbourn Hall
Radiology: Walker Hall
Surgery: South Kilbourn Hall

SCIENTIFIC SESSIONS

STATE MEDICAL SOCIETY of WISCONSIN 1948 Annual Meeting MILWAUKEE·OCT·4·5·6

MONDAY, OCTOBER 4

9:00–11:30 a. m.

1. PEDIATRIC CLINIC—CHILDREN'S HOSPITAL : 721 No. Seventeenth St.

Program arranged by Francis R. Janney, M. D., Wauwatosa

Chairman and Coordinator: John L. Garvey, M. D., Milwaukee

"Neurological Conditions in Infancy and Childhood—Medical and Surgical":

"Medical Aspects, Especially the Meningitides": F. J. Mellencamp, M. D.
"The Outlook and Indications for Surgery of Meningocele": A. A. Schaefer, M. D.
"Subdural Hematoma": Harry P. Maxwell, M. D.
"Brain Abscesses and Brain Tumors": Harry Cleveland, M. D.
"Convulsions": M. G. Peterman, M. D.

Patients will be presented to coordinate the presentations of the above topics.

2. MILWAUKEE COUNTY HOSPITAL CLINIC : 8700 West Wisconsin Ave.*

J. M. King, M. D., and F. D. Murphy, M. D., chairmen

9:00– 9:30 a. m. **"Diseases of the Liver"**
"Diagnosis and Medical Management"—Merle C. F. Lindert, M. D.
"Surgical Management"—James G. Garland, M. D.

9:30–10:00 a. m. **"Peptic Ulcer"**
"Medical Management"—Joseph Shaiken, M. D.
"The Surgery of Its Complications"—Conde F. Conroy, M. D.

10:00–10:30 a. m. **"Peripheral Vascular Diseases"**
"Medical Aspects"—Joseph W. Rastetter, M. D.
"Surgical Management"—Joseph J. Gramling, M. D.

10:30–10:45 a. m. **"Present Status of Colonic Surgery"**—Joseph M. King, M. D.

10:45–11:00 a. m. **"The Proper Use of the Diuretics"**—Francis D. Murphy, M. D.

3. VETERANS HOSPITAL : West National Ave., West Allis*

Maurice Hardgrove, M. D., chairman

9:00– 9:20 a.m. **"Thoracic Amebiasis"**—Mischa J. Lustok, M. D., and Mark W. Garry, M. D.

9:20– 9:40 a.m. **"Diabetes Mellitus"**—B. J. Peters, M. D., and Maurice Hardgrove, M. D.

9:40–10:00 a.m. **"Peripheral Vascular Disease"**—Robert A. Frisch, M. D., and Ralph T. Cunningham, M. D.

Forrester Raine, M. D., chairman

10:00–10:20 a. m. **"Thrombophlebitis"**—James M. Sullivan, M. D., and Howard L. Correll, M. D.

10:20–10:40 a. m. **"Peptic Ulcer: Surgical Treatment"**—Charles M. Schroeder, M. D.

10:40–11:00 a. m. **"Plastic Principles of Use in General Surgery"**—William H. Frackelton, M. D.

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* Buses for Milwaukee County Hospital and Veterans Hospital will leave Hotel Schroeder promptly at 8:15 a.m., and will return at 11:45 a. m., in time for noon luncheons. *Advance reservations required!*

MONDAY, OCTOBER 4

12:15–2:15 p. m.: ROUND-TABLE LUNCHEONS—See page 793

2:30–5:00 p. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

N. H. TOPPING, M. D.

2:30– 3:00 p. m.: **"Research Progress on the Common Cold"**: NORMAN H. TOPPING, M. D., U. S. Public Health Service, National Institute of Health, Bethesda, Maryland, and adjunct professor of medicine, George Washington University School of Medicine; professorial lecturer, Georgetown University School of Medicine, Washington, D. C.

3:00– 3:30 p. m.: **"Carcinoma of the Lung"**: EVARTS A. GRAHAM, M. D., professor of surgery, Washington University School of Medicine, St. Louis (lecture sponsored by Wisconsin Division of the American Cancer Society)

3:30– 4:00 p. m.: **RECESS TO VIEW EXHIBITS**

E. A. GRAHAM, M. D.

4:00– 4:15 p. m.: **"Rheumatic Fever — Its Early Diagnosis"**: S. F. MORGAN, M. D., associate professor of pediatrics, Marquette University School of Medicine, Milwaukee

4:15– 4:30 p. m.: **"Rheumatic Fever — Its Treatment"**: C. M. KURTZ, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

4:30– 5:00 p. m.: **"Emotional Aspects of Organic Diseases"**: H. W. BROSIN, M. D., professor of psychiatry, University of Chicago, The School of Medicine, Chicago (lecture sponsored by the Mental Hygiene Division, State Board of Health)

H. W. BROSIN, M. D.

★

SIMULTANEOUS MEDICAL MOTION PICTURES

On each of the three days of the Annual Meeting there will be shown a full program of scientific medical teaching films being selected by H. Kent Tenney, M. D., Madison. The complete schedule will be carried in the September issue of *The Wisconsin Medical Journal.* The program for Monday afternoon will be printed in this portion of the program.

Monday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor B: SURGICAL CONDITIONS OF THE LUNGS: E. A. Graham, professor of surgery, Washington University School of Medicine, St. Louis, Missouri.

2. Parlor C: NEWER DRUGS AND THEIR USAGE: W. S. Middleton, professor of medicine and dean of the University of Wisconsin Medical School, Madison.

3. Parlor D: THE COLLABORATIVE ROLE OF THE FEDERAL GOVERNMENT IN MEDICAL RESEARCH: N. H. Topping, Federal Security Agency, U. S. Public Health Service, Bethesda, Maryland.

4. Parlor E: TREATMENT PROBLEMS IN EMOTIONAL DISORDERS: H. W. Brosin, professor of psychiatry, University of Chicago Medical School, Chicago.

5. Parlor F: RHEUMATIC HEART DISEASE: C. M. Kurtz, associate professor of medicine, University of Wisconsin Medical School, Madison; and S. F. Morgan, associate professor of pediatrics, Marquette University School of Medicine, Milwaukee.

6. Parlor H: ACUTE EMERGENCIES IN PEDIATRICS: F. R. Janney, professor of pediatrics, Marquette University School of Medicine, Milwaukee.

7. Parlor I: GASTROINTESTINAL BLEEDING—ITS CAUSES AND TREATMENT: J. M. King, associate professor of surgery, Marquette University School of Medicine, Milwaukee.

SPECIAL LUNCHEONS

8. Parlor A: County Secretaries' Luncheon (by invitation only).

9. Parlor G: Past Presidents' Luncheon (by invitation only).

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FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: SURGICAL LESIONS OF THE ESOPHAGUS: Forrester Raine, associate professor of surgery, Marquette University School of Medicine, Milwaukee.

11. Private Dining Room C: ALLERGIC DISEASES: T. L. Squier, clinical associate professor of medicine, Marquette University School of Medicine, Milwaukee.

OB MANIKIN DEMONSTRATION

12. Pere Marquette Room (5th Floor): EMOTIONAL PROBLEMS OF EXPECTANT MOTHERS: D. M. Britton, Madison. (Doctor Britton will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

[SEE PAGE 795 FOR RESERVATION BLANK]

MARQUETTE ALUMNI DINNER: The Marquette University Medical Alumni Dinner will be held Monday, October 4 at 6:00 p.m. in the Pere Marquette Room of the Hotel Schroeder. Principal speaker will be Dr. John S. Hirschboeck, dean of the Marquette University School of Medicine. An award to an outstanding alumnus for service to Marquette and achievement in the medical profession will be made. Dr. Max J. Fox, president of the Marquette University Medical Alumni Association, will preside. Reservations can be made by contacting the Marquette University Alumni Association, 1533 West Wisconsin Avenue, Milwaukee 3.

MAZUR POLISH DANCERS OF MILWAUKEE

Dances, Movies Featured at Smoker

MONDAY EVENING OCTOBER 4 HOTEL SCHROEDER

Varied Program of Singing, Dances and Unusual Color Movies
W. C. FINN, M. D., Fond du Lac, *Master of Ceremonies*

Light refreshments—8:30–10:30 p. m.—Lots of fun!

Informal "singfest" led by "Marge" Schiff—well known to physicians who have attended Smokers other years.

Folk Dances and Folk Songs: Under direction of Miss Dorothy Endris, Director of Recreation, Milwaukee Public Schools

Color motion pictures of American wild-life: R. V. Landis, M. D., Appleton. Doctor Landis has received wide acclaim for his color photography. He will comment on the pictures as shown.

All physicians and exhibit representatives invited!
No reservations needed.

Luncheon and Dinner Reservations

If you have not already done so, send in your luncheon and dinner reservations *today*. Many luncheons are already filled, so be sure to list below three selections, in order of preference, for each of the days you will be in attendance.

Mail to: C. H. CROWNHART, *Secretary*
State Medical Society of Wisconsin
917 Tenney Building
Madison 3, Wisconsin

Cost of Luncheons: $2.00 per plate (Including gratuities)
Cost of Dinner : $4.00 per plate (Including gratuities)

Luncheon for MONDAY, OCTOBER 4

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for TUESDAY, OCTOBER 5

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Luncheon for WEDNESDAY, OCTOBER 6

	Luncheon Number	*Luncheon Leader*
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

Dinner—

TUESDAY, OCTOBER 5

Reserve _____ places for me at $4.00 per plate.

Signed _____

Address _____

(*Make Your Check Payable to:* THE STATE MEDICAL SOCIETY OF WISCONSIN)

Clinical Conference Reservation . . .

(See page 791 for program)

I will attend the Clinic at _____ on Monday morning, October 4.
If you are attending Clinic at Milwaukee Hospital or Veterans Hospital, fill in line below.
Reserve a seat for me on the bus leaving the Hotel Schroeder at 8:15 a.m., Monday, October 4 _____.

TUESDAY, OCTOBER 5

9:00–11:30 a. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

J. B. YOUMANS, M. D.

H. P. GREELEY, M. D.

ARNOLD GESELL, M. D.

9:00– 9:20 a. m.: "Treatment of Carcinoma of the Prostate Gland": JAMES C. SARGENT, M. D., professor of urology, Marquette University School of Medicine, Milwaukee

9:20– 9:50 a. m.: "The Place of Nutrition in Medical Practice": JOHN B. YOUMANS, M. D., dean, University of Illinois College of Medicine, Chicago

9:50–10:10 a. m.: "The Role of Isotopes in the Treatment of Thyroid Disease": EDGAR S. GORDON, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

10:10–10:40 a. m.: RECESS TO VIEW EXHIBITS

10:40–11:00 a. m.: "Iatrogenic Disease": HUGH PAYNE GREELEY, M. D., department of internal medicine, Lahey Clinic, Boston

11:10–11:40 a. m.: "A Clinical Science of Child Development": ARNOLD GESELL, M. D., professor of child hygiene, Yale University School of Medicine, New Haven, Connecticut

12:15– 2:15 p. m.: ROUND-TABLE LUNCHEONS

2:30– 3:00 p. m.: "Surgical Complications of Amebiasis": MICHAEL E. DEBAKEY, M. D., associate professor of surgery, Tulane University of Louisiana School of Medicine, New Orleans

3:00– 3:30 p. m.: "Arthritis of the Spine—Diagnosis and Management": RICHARD H. FREYBERG, M. D., associate professor of clinical medicine, Cornell University Medical College, New York

3:30– 4:00 p. m.: RECESS TO VIEW EXHIBITS

4:00– 4:30 p. m.: "Some Aspects of Treatment of Emotional Illness": HARRY M. MURDOCK, assistant professor of psychiatry, University of Maryland School of Medicine, Baltimore (lecture presented under sponsorship of the Rogers Memorial as the Theresa Rogers Memorial Lecture on Psychiatry)

4:30– 5:00 p. m.: "Office Gynecology": JOSEPH L. BAER, M. D., Chicago

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7:00 p. m.: **Annual Dinner:** The Annual Dinner will feature an address by H. C. UREY, Ph. D., Nobel Prize winner and member of the University of Chicago faculty. The dinner will be preceded by a president's reception, to which all those who attend the dinner are invited. Distinguished guests, including Professor Urey and the governor of Wisconsin will be honored at the reception.

The "50 Year Club" members will be honored guests at the Annual Dinner. New members will be formally received into membership at that time.

Tuesday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor A: GUIDANCE MEASURES FOR HANDICAPPED CHILDREN: Arnold Gesell, professor of child hygiene, Yale School of Medicine.
2. Parlor B: VITAMINS IN TREATMENT: J. B. Youmans, dean, University of Illinois College of Medicine, Chicago.
3. Parlor C: HYPERTENSION: H. P. Greeley, Lahey Clinic, Boston.
4. Parlor D: COMMON FORMS OF NONARTICULAR RHEUMATISM: R. H. Freyberg, associate professor of clinical medicine, Cornell University Medical College.
5. Parlor E: CAESAREAN SECTION: J. L. Baer, Chicago.
6. Parlor F: NEWER DRUGS AND THEIR USE: O. O. Meyer, professor of medicine, University of Wisconsin Medical College.
7. Parlor G: SOME DIFFICULT METABOLIC OR ENDOCRINE PROBLEMS: E. S. Gordon, associate professor of medicine, University of Wisconsin Medical School, Madison.
8. Parlor H: COUNTY AND CITY-COUNTY HEALTH DEPARTMENTS FOR WISCONSIN: C. N. Neupert, director, State Board of Health, Madison.
9. Parlor I: INDUSTRIAL HAZARDS PECULIAR TO WISCONSIN INDUSTRY: E. L. Belknap, Milwaukee.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: SURGERY OF THE SYMPATHETIC NERVOUS SYSTEM: M. E. DeBakey, associate professor of surgery, School of Medicine, Tulane University of Louisiana, New Orleans.
11. Private Dining Room C: ECTOPIC PREGNANCY: Frank Whitacre, professor of obstetrics and gynecology, The University of Tennessee College of Medicine, Memphis.
12. Private Dining Room D: PSYCHIATRIC TRAINING FOR PHYSICIANS IN OTHER FIELDS: H. M. Murdock, assistant professor of psychiatry, University of Maryland School of Medicine.
13. Committee Room: INDUSTRIAL DERMATOSES: H. R. Foerster, associate professor of dermatology, Marquette University School of Medicine, Milwaukee.
14. Pine Room: NASAL ALLERGY: G. E. Shambaugh, Jr., assistant professor of otolaryngology, Northwestern University Medical School, Chicago.

OB MANIKIN DEMONSTRATION

15. Pere Marquette Room (5th Floor): OBSTETRICAL CASE PROBLEMS: F. J. Stoddard, clinical instructor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee. (Doctor Stoddard will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

[SEE PAGE 795 FOR RESERVATION BLANK]

R. H. FREYBERG, M. D.

M. E. DeBAKEY, M. D.

H. M. MURDOCK, M. D.

J. L. BAER, M. D.

WEDNESDAY, OCTOBER 6

9:00–11:30 a. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

O. H. WANGENSTEEN, M. D.

9:00– 9:20 a. m.: "An Analysis of the Causes of Failures in Fractures of the Neck of the Femur": C. C. SCHNEIDER, M. D., Milwaukee

9:20– 9:40 a. m.: "Changing Concepts in Bowel Surgery": A. C. GORDER, M. D., Milwaukee

9:40–10:10 a. m.: "The Ulcer Problem": OWEN H. WANGENSTEEN, M. D., professor and chief, department of surgery, University of Minnesota Medical School, Minneapolis

10:10–10:40 a. m.: RECESS TO VIEW EXHIBITS

B. R. KIRKLIN, M. D.

10:40–11:10 a. m.: "Cancer of the Stomach": B. R. KIRKLIN, M. D., professor of radiology, Graduate School, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

11:10–11:40 a. m.: "Treatment of Leukemia": CHARLES WATKINS, M. D., associate professor of medicine, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

Simultaneous Medical Motion Pictures

During the morning scientific session there will be a repeat showing of the medical motion pictures shown on the previous two days. See this portion of the program as printed in the September *Journal* for a detailed schedule of the films to be shown Wednesday morning.

Wednesday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor A: EARLIER RECOGNITION OF ALIMENTARY TRACT MALIGNANCY: O. H. Wangensteen, professor of surgery, University of Minnesota Medical School, Minneapolis.
2. Parlor B: CONVULSIONS IN CHILDREN: F. A. Gibbs, associate professor of psychiatry, University of Illinois School of Medicine.
3. Parlor C: ALLERGY IN PEDIATRICS: W. Ambrose McGee, Richmond.
4. Parlor D: NEWER DRUGS AND THEIR USES: F. D. Murphy, head of the Department of Medicine, Marquette University School of Medicine, Milwaukee.
5. Parlor E: HYPOTHYROIDISM IN CHILDREN: R. L. J. Kennedy, professor of pediatrics, Mayo Foundation, University of Minnesota Medical School, Minneapolis, and on staff of Mayo Clinic, Rochester.
6. Parlor F: LEUKEMIAS: Charles Watkins, associate professor of medicine, University of Minnesota Medical School, Minneapolis, and head, Section on Pediatrics, Mayo Clinic, Rochester.
7. Parlor G: THE PROBLEM OF BENIGN HYPERTROPHY OF THE PROSTATE: Ira R. Sisk, professor of urology, University of Wisconsin Medical School, Madison.
8. Parlor H: HAND INFECTIONS: W. H. Frackelton, Milwaukee.
9. Parlor I: COMMON RECTAL COMPLAINTS AND THEIR TREATMENT: A. C. Gorder, Milwaukee.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: PAPANICOLAOU SMEAR TECHNIQUE AND ITS APPLICATION IN CLINICAL MEDICINE: W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison.
11. Private Dining Room C: ECONOMIC PROBLEMS OF RADIOLOGY: S. R. Beatty, Oshkosh.
12. Private Dining Room D: THE PATHOLOGY OF CORONARY ARTERY DISEASE: W. B. Wartman, chairman, Dept. of Pathology, Northwestern University Medical School, Chicago. General discussion under direction of W. A. D. Anderson, Marquette University School of Medicine, Milwaukee.
13. Pine Room: NEWER DIAGNOSTIC METHODS: F. W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee.

OB MANIKIN DEMONSTRATION

14. Pere Marquette Room (5th Floor): THE EVALUATION OF LABOR: R. L. Cowles, Green Bay. (Doctor Cowles will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

SPECIAL EENT LUNCHEON

15. Banquet Room (5th Floor): J. K. Trumbo, chairman, Wausau. Following luncheon Dr. F. A. Davis will show his motion pictures on CATARACT OPERATIONS, illustrating different methods of incision and closure of the wound.

[SEE PAGE 795 FOR RESERVATION BLANK]

SECTION MEETINGS

MILWAUKEE AUDITORIUM
2:30–5:30 P. M.—OCTOBER 6

GENERAL PRACTICE

ENGELMAN HALL
Milwaukee Auditorium

WOODRUFF SMITH, M. D.
Chairman

p. m.
2:15 "The Care of Hip Fractures in a Rural Community": R. L. MacCornack, M. D., and R. M. Rogers, M. D., Whitehall
2:35 Discussion
2:50 "Some Aspects of Cardiovascular Disease in the Elderly Patient": H. P. Greeley, M. D., department of internal medicine, Lahey Clinic, Boston
3:20 Discussion
3:30 Recess
3:45 "The Handling of the Menopause Group": H. M. Murdock, M. D., assistant professor of psychiatry, University of Maryland School of Medicine, Towson, Maryland
4:15 Open discussion on purpose and future of Section on General Practice

★

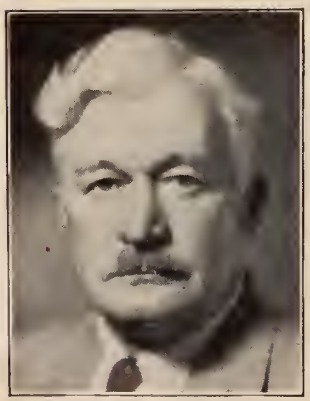
INTERNAL MEDICINE

PLANKINTON HALL
Milwaukee Auditorium

ELWOOD MASON, M. D.
Chairman

p. m.
2:15 "Some Aspects of Nutritional Anemias": J. B. Youmans, M. D., dean, University of Illinois College of Medicine, Chicago
2:45 "Treatment of Tuberculosis with Streptomycin": G. C. Owen, M. D., clinical instructor in medicine, Marquette University School of Medicine, Milwaukee
3:05 Discussant: John D. Steele, Jr., M. D., assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee
3:15 Recess
3:40 "Diagnosis of Lymph Node Enlargement": J. S. Hirschboeck, M. D., dean, Marquette University School of Medicine, Milwaukee
4:00 "What Is Rheumatoid Arthritis?": R. H. Freyberg, M. D., associate professor of clinical medicine, Cornell University Medical College, New York City
4:30 Open Discussion
4:50 Business Meeting

★



OBSTETRICS AND GYNECOLOGY

SOUTH JUNEAU HALL
Milwaukee Auditorium

C. S. HARPER, M. D.
Chairman

p. m.
2:15 "The Physiology of the Endocrines as Related to Obstetrics and Gynecology": R. K. Meyer, Ph.D., professor of zoology, University of Wisconsin, Madison
2:35 "The Use of Endocrine Products in Obstetrics and Gynecology": P. F. Schneider, M. D., instructor in obstetrics and gynecology, Northwestern University Medical School, Evanston, Illinois
3:05 Discussant: A. A. Cantwell, M. D., Shawano
3:15 General discussion of previous papers
3:35 Recess
3:45 "Eclamptic Toxemia": F. E. Whitacre, M. D., professor and head of department of obstetrics and gynecology, University of Tennessee College of Medicine, Memphis, Tennessee
4:15 Discussant: T. A. Leonard, M. D., Madison
4:25 "Distribution of Whole Blood, Blood Plasma, and Blood Products Through Community Blood Banks": W. D. Stovall, M. D., professor of hygiene, University of Wisconsin Medical School, Madison

GUEST SPEAKERS—SECTION MEETINGS

FRANK WHITACRE
Memphis, Tenn.
Section on Obstetrics and Gynecology

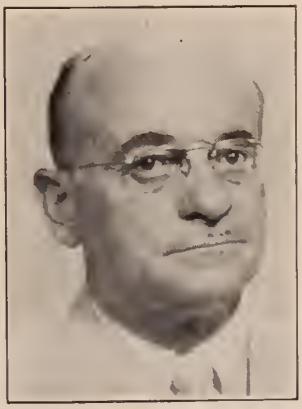
G. E. SHAMBAUGH, JR.
Chicago
Section on Ophthalmology and Otolaryngology

W. A. McGEE
Richmond, Va.
Section on Pediatrics

A. D. PRANGEN
Rochester, Minn.
Section on Ophthalmology and Otolaryngology

R. L. J. KENNEDY
Rochester, Minn.
Section on Pediatrics

F. A. GIBBS
Chicago
Section on Pediatrics



PHILIP SCHNEIDER
Chicago
Section on Obstetrics and Gynecology

WEDNESDAY, OCTOBER 6

OPHTHALMOLOGY AND OTOLARYNGOLOGY

NORTH JUNEAU HALL
Milwaukee Auditorium

J. K. TRUMBO, M. D.
Chairman

p. m.
2:15 "Clinical Allergy for the Nose and Throat Specialists": T. L. Squier, M. D., associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

2:35 Open Discussion

2:45 "The Fenestration Operation: Selection of Cases and Training of the Surgeon": G. E. Shambaugh, Jr., M. D., assistant professor of otolaryngology, Northwestern University Medical School, Chicago

3:15 Open Discussion

p. m.
3:25 Recess

3:35 "The Accommodative and Convergence Factors in Refraction": A. D. Prangen, M. D., associate professor of ophthalmology, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

4:05 Open Discussion

4:15 "The Incision and Closure of the Wound in Cataract Operations": F. A. Davis, M. D., professor of ophthalmology, University of Wisconsin Medical School, Madison

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PEDIATRICS

NORTH KILBOURN HALL
Milwaukee Auditorium

M. G. PETERMAN, M. D.
Chairman

p. m.
2:15 "Exophthalmic Goiter in Children": R. L. J. Kennedy, M. D., professor of pediatrics, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

2:45 "Practical Aspects of Electroencephalography": F. A. Gibbs, M. D., associate professor of psychiatry, University of Illinois College of Medicine, Chicago

3:15 Recess

p. m.
3:30 "Differential Development Diagnosis": Arnold Gesell, M. D., professor of child hygiene, Yale University School of Medicine, New Haven, Connecticut

4:00 "Pediatric Allergy": W. A. McGee, M. D., Richmond, Virginia

4:20 "What the Practitioner May Expect from the Laboratory": Gorton Ritchie, M. D., Milwaukee

4:40 "Some Problems in Roentgenology in Children": J. L. Marks, M. D., clinical instructor in radiology, Marquette University School of Medicine, Milwaukee

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RADIOLOGY

WALKER HALL
Milwaukee Auditorium

S. R. BEATTY, M. D.
Chairman

p. m.
2:15 "Cholecystography": B. R. Kirklin, M. D., professor of radiology, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

2:45 Discussion

3:00 "X-Ray Therapy of Myositis Ossificans": E. A. Pohle, M. D., professor of radiology, and J. H. Juhl, M. D., resident in radiology, University of Wisconsin Medical School, Madison

3:15 "A Pediatric Case Report": H. W. Hefke, M. D., assistant clinical professor of radiology, Marquette University School of Medicine, Milwaukee

p. m.
3:30 Recess

3:45 Case Report: S. A. Morton, M. D., Milwaukee

4:00 Case Report: H. H. Wright, M. D., assistant clinical professor of radiology, Marquette University School of Medicine, Milwaukee

4:15 Case Report: M. C. Prichard, M. D., Eau Claire

4:30 "Adenoma of the Bronchus": L. W. Paul, M. D., professor of radiology, University of Wisconsin Medical School, Madison

WEDNESDAY, OCTOBER 6

SURGERY

SOUTH KILBOURN HALL
Milwaukee Auditorium

F. D. WEEKS, M. D.
Chairman

p. m.
2:15 "Carcinoma of the Ampulla of Vater": K. E. Lemmer, M. D., associate professor of surgery, University of Wisconsin Medical School, Madison

2:35 Discussant: Irwin Schulz, M. D., Milwaukee

2:45 "Present Status of Vagal Resection": P. A. Midelfart, M. D., Eau Claire

3:05 Discussant: Forrester Raine, M. D., associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:15 "Carcinoma of the Breast": C. W. Eberbach, M. D., associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:35 Discussant: J. W. McRoberts, M. D., Sheboygan

p. m.
3:45 Recess

4:00 "The Surgical Treatment of Colon Malignancy": O. H. Wangensteen, M. D., professor and chief, department of surgery, University of Minnesota Medical School, Minneapolis

4:30 Discussant: E. R. Schmidt, M. D., professor of surgery, University of Wisconsin Medical School, Madison

4:40 "The Surgical Treatment of Peripheral Vascular Disease": M. E. DeBakey, M. D., associate professor of surgery, Tulane University of Louisiana School of Medicine, New Orleans

5:10 Discussant: J. M. Sullivan, M. D., assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

★ SCIENTIFIC EXHIBITS ★

Scientific exhibits have been selected by F. W. Madison, M. D., Milwaukee. The exhibits will be located in the north half of the Main Arena of the Milwaukee Auditorium and on the stage of the Auditorium, directly back of the registration desk. Plan to visit them.

S–8 "Cytological Diagnosis of Cancer"
S–8a

State Laboratory of Hygiene, State Board of Health

This exhibit demonstrates the Papanicolaou method for the recognition of malignant cells in body fluids and exudates. It shows the method of collecting the specimen, preserving it, and forwarding it to a laboratory prepared to do these smears, and the character of normal cells and malignant cells. It illustrates the use of this method for the diagnosis of bronchogenic carcinoma, carcinoma of the cervix and uterus, and malignant disease revealed by the examination of fluid secured from the abdominal cavity, pleural cavity, and urine.

S–9 "Peripheral Vascular Disorders"
S–10

R. A. Frisch, M. D., J. M. Sullivan, M. D., S. S. Zintek, M. D., Maurice Hardgrove, M. D., and Ray Piaskoski, M. D., Veterans Hospital, Wood

This will be a presentation of peripheral vascular disorders that have been reviewed by the Peripheral Vascular Board at the Veterans Hospital, Wood, Wisconsin, composed of members of the departments of medicine, surgery, and physical medicine, with results of various methods of treatment. Illustrations of graphs and kodachrome slides are shown. The use of thermocouple and oscillometer is demonstrated.

S–11 "Demonstration of Pathologic Specimens"

Wisconsin Society of Pathologists

Through the cooperation of various members of the Wisconsin Society of Pathologists, a demonstration of pathologic specimens will be made available with discussion of the lesions. The types of specimens will depend on the material available at the time of the demonstration.

S–12 "Rehabilitation Program for Hare Lip and
S–13 Cleft Palate Children"

W. B. Slaughter, M. D., H. K. Tenney, M. D., W. R. Plater, D. D. S., and N. Glupker, D. D. S., in cooperation with the Bureau of Handicapped Children, State Department of Public Instruction

The exhibit is based on records of incidence and frequency from the State Board of Health. All phases of treatment, including plastic surgery, orthodontia, prostheses, speech, and social service will be demonstrated, as well as the correlation of these services to the fields of pediatrics and anesthesia.

S–14 "Junior League Blood Center of Milwaukee, Inc."

T. J. Greenwalt, M. D., Milwaukee

This exhibit will consist essentially of about 25 charts, measuring approximately 16′ by 22′,

describing the growth of the blood center, the procedures used, and the products produced. In addition, there will be a small display of transfusion equipment and a small box of kodachrome transparencies.

S–14a "Hyperthyroidism—Diagnosis and Treatment.
S–20a Use of Propylthiouracil, Iodine, and Surgery"

Arnold Jackson, M. D., Jackson Clinic, Madison

This exhibit, located directly in front of the registration desk, demonstrates, by the use of colored photography, charts, moulages, and drawings, the various aspects of hyperthyroidism—the diagnosis, the use of iodine and propylthiouracil in the treatment, and the various steps in the surgical removal of goiter. The exhibit calls special attention to the use of propylthiouracil, and colored photographs and charts demonstrate the effect of this drug on cases of hyperthyroidism in children as well as adults. The indication for and against the use of the drug as determined by a study of 175 cases of toxic goiter is discussed.

S–15 "Needle Biopsy of the Liver in Diagnosis of Hepatic Disease"

M. C. F. Lindert, M. D., Milwaukee

Enlarged photomicrographs in color of hepatic diseases diagnosed by means of needle biopsy of the liver are the central theme of the exhibit. In addition, historical data will be printed and actual needles used by several investigators in this field will be shown. A section depicting the use of special diagnostic measures (alkaline phosphatase stain and iron stain) by enlarged color photomicrographs and one pointing out the potentialities of the procedure complete the exhibit.

S–16 "Physical Medicine Rehabilitation Service"
S–17

Ray Piaskoski, M. D., and George M. Reichle, M. D., Veterans Administration Center, Wood

A typical rehabilitation service in a Veterans Administration Hospital, showing the integrated program of physical therapy, occupational therapy, corrective therapy, manual arts and educational therapy, social service, recreation and vocational guidance—all designed to aid and motivate the patient to early recovery and restore him to a useful place in his community—will be illustrated.

S–18 Section on Radiology
S–19

(See official program for details)

S–20 "Pulmonary Resection for Tuberculosis Clin-
S–21 icopathologic Study"

University of Wisconsin Departments of Surgery, Medicine, X-Ray, and Pathology. J. W. Gale, M. D., in charge.

The exhibit shows colored and black and white transparencies of twenty cases of pulmonary resection for pulmonary tuberculosis, covering the known indications. A clinicopathologic study including history, x-rays, gross specimens, and microscopic specimens complete the exhibit.

S–22 "Chemotherapy of Ocular Infections—Sul-
S–23 fonamides and Antibiotics"

J. G. Bellows, M. D., and C. J. Farmer, M. D., Chicago

The exhibit shows the distribution of sulfonamide compounds, penicillin, and streptomycin between the blood and ocular fluids and tissues. A series of experimental extraocular and intraocular infections induced in rabbits' eyes by various organisms is shown by means of transparencies, together with clinical cases. The therapeutic agents employed in this study include the sulfonamide drugs, penicillin, streptomycin, gramicidin, tyrothricin, and bacitracin. The sites of the commoner types of infection are shown diagrammatically, with the drug of choice. Methods of treatment, including corneal baths, with and without ion transfer and intraocular injections, are illustrated.

S–24 "Chemosurgical Treatment of Cancer: A Mi-
S–25 croscopically Controlled Method of Excision"

F. E. Mohs, M. D., Madison

The chemosurgical technic by which the microscopic control of excision is attained is described and illustrated by photographs of patients with lesions in various stages of treatment. Transparencies illustrate the various types of external neoplasms that are amenable to chemosurgical treatment. Pictures of the lesions before, during, and after treatment are included. Reconstructions of cancers show the "silent" outgrowths from the main mass of tumor and emphasize the need for the microscopic control of excision. Charts present the rates of cure in the three year and five year periods.

S–26a "Common Industrial Poisons—Recognition and Control"

E. L. Belknap, M. D., Milwaukee

The exhibit will consist of charts, slides, and microscopic demonstrations covering the subjects of lead, carbon tetrachloride, benzol, and cadmium fumes as examples of toxic dusts, vapors, and fumes affecting industrial workers. The importance of industrial medicine to the general practitioner is emphasized in the exhibit.

S–26 Anatomy Exhibits of the University of Wis-
S–27 consin Medical School and Marquette Uni-
S–28 versity School of Medicine
S–29

(See official program for details of this joint exhibit)

S–30 "How Anti-Vivisection Handicaps Medical Progress"

National Society for Medical Research, Chicago

Information is based on surveys conducted by the National Society for Medical Research, showing the extent of antivivisection obstructionism, examples of antivivisection propaganda, technics and descriptions of work which the National Society for Medical Research is doing to overcome antivivisection obstructionism.

S–31 "Carcinoma of the Esophagus"

Forrester Raine, M. D., Milwaukee

The exhibit will consist of models of the esophagus and stomach, showing high and low carcinoma of the esophagus and the surgical removal and reconstruction by gastroesophageal anastomosis.

SS–1 "Mycologic Diagnosis"

Esther Meyer, M. D., Chicago, and Marvin Kagen, M. D., Appleton

The salient features of the symptoms and signs of the deep and superficial fungus diseases are listed, along with the specific drugs used in therapy. The methods for making mycologic diagnoses are illustrated and described. Colored photographs of the microscopic observations and cutaneous lesions, giant colonies, and anaerobic cultures are presented. The aim will be to the general practitioner an approach to making a diagnosis of a fungus disease.

This exhibit will be located at the foot of the stage directly west of the registration desk.

SS–2 "Siderosis; A Benign Pneumoconiosis Due to Iron Fumes and Dusts"

O. A. Sander, M. D., Milwaukee

This exhibit will be located at the foot of the stage, directly east of the registration booth. It will summarize a 15 year series of periodic chest roentgenograms of eight welders, steel cutters, and grinders, along with the pathologic sections from an additional case. The x-ray findings are characterized by discrete nodular and stippled shadows due to iron oxide deposits in the perivascular lymphatics. Such iron pigmentation is entirely inert, with no resulting fibrosis, impaired lung function, or increased susceptibility to tuberculosis or other infections. It is of significance only because of its frequent misdiagnosis as silicosis.

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EXHIBITS LOCATED ON STAGE OF AUDITORIUM

ST–1 Milwaukee Division of the American Cancer
ST–2 Society

(See official program for details)

ST–3 Exhibit of the National Foundation for In-
ST–4 fantile Paralysis

(See official program for details)

ST–5 "Relief of Hypertension by Sympathectomy"

James E. Conley, Milwaukee

Relief of the hypertensive state by thoracolumbar splanchnicectomy (Smithwick operation) will be displayed. Relief of the cardiac status will be shown by changes in the electrocardiogram and x-ray studies. There will be a brief note on the effects of sympathectomy, both the desirable and untoward effects.

ST–6 Wisconsin Anti-Tuberculosis Association
ST–7

This will be a presentation of interesting chest x-ray films by WATA physicians, alternating with sound movies, one of which is entitled "Routine Admission Chest X-Rays in General Hospitals." Free literature can be obtained, and educational and informational material may be viewed on the panels.

ST–8 "Health Films Shown to the Public"

Wisconsin State Board of Health

The Wisconsin State Board of Health will show films on "Environmental Sanitation," "Sex Education," "Safety," and "Mental Health." These films are among the many which are available for loan without charge to residents of Wisconsin and which are being used extensively by schools and adult groups throughout the state. A catalog giving a descriptive list of all films available will be distributed at the booth.

ST–9 "The Cancer Problem Today: Early Diagnosis"
ST–10

Wisconsin Division, American Cancer Society

Through a series of photographs, the cardinal signs of cancer are illustrated. Two charts emphasize the responsibility for delay in the diagnosis of cancer. Theme: "With few exceptions the life of the cancer patient is in the hands of the first physician he sees."

ST–11 "Rheumatism: King of Human Misery"

Wisconsin Rheumatism Association

(See official program for details)

ST–12 "The Differential Diagnosis of Congenital Heart Disease"

Gorton Ritchie, M. D., and Francis Rosenbaum, M. D., Milwaukee, for the Wisconsin Heart Association

Examples of congenital cardiovascular disturbances corrected by surgical procedures are presented. These are contrasted with other congenital cardiac lesions from which they may be differentiated. The major diagnostic features of each disorder are outlined.

ST–13 "Cancer in the Medical School Curriculum"
ST–14

Marquette University School of Medicine, Milwaukee

This exhibit is intended to show the manner in which cancer teaching is being correlated through the cooperation of the various departments of Marquette University. The program will be outlined by charts. In addition, there will be slides and photographs relating to breast and cervical cancers. Technics for the development of teaching material will be demonstrated. These technics will be the Papanicolaou smear method, demonstration models, and some aids in photography.

House of Delegates—1948

PLACE OF MEETING:

Banquet Room, Fifth Floor, Hotel Schroeder.

SCHEDULE OF MEETINGS:

Sunday, October 3; 1:30 p. m.

Monday, October 4; 6:00 p. m.

Tuesday, October 5; 9:00 a. m.

MEETINGS OF REFERENCE COMMITTEES:

Organizational Meetings: Sunday, 7:00 p. m.

Open Meetings: Monday, 9:00 a. m.

Committee on Credentials: At Registration Table outside of Banquet Room (fifteen minutes before each session of the House).

Committee on Reports of Officers: Room C, Fifth Floor, Hotel Schroeder.

Committee on Resolutions and Amendments to the Constitution and By-Laws: Banquet Room, Fifth Floor, Hotel Schroeder.

Committee on Reports of Standing Committees: Room B, Fifth Floor, Hotel Schroeder.

Committee on Nominations: Committee Room, Fifth Floor, Hotel Schroeder (directly north of Banquet Room). 9:00–10:00 open meeting; 10:00 on, executive session.

Society	*Delegates*	*Alternate*
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	W. E. Bargholtz, Ashland
Barron–Washburn–Sawyer–Burnett	S. O. Lund, Cumberland	O. E. Rydell, Rice Lake
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	W. P. Tippet, Green Bay
	A. J. McCarey, Green Bay	W. A. Killins, Green Bay
Calumet	A. C. Engel, New Holstein	E. W. Humke, Chilton
Chippewa	S. E. Williams, Chippewa Falls	J. J. Sazama, Chippewa Falls
Clark	M. V. Overman, Neillsville	H. H. Christofferson, Colby
Columbia–Marquette–Adams	R. B. Dryer, Poynette	J. H. Houghton, Wisconsin Dells
Crawford	E. H. Lechtenberg, Prairie du Chien	T. F. Farrell, Prairie du Chien
Dane	T. A. Leonard, Madison	A. T. Smedal, Stoughton
	C. G. Reznicheck, Madison	J. P. Malec, Madison
	L. R. Cole, Madison	J. H. Robbins, Madison
	J. S. Supernaw, Madison	B. I. Brindley, Madison
	L. V. Sprague, Madison	J. A. Hurlbut, Madison
Dodge	M. M. Temkin, Beaver Dam	A. B. Kores, Beaver Dam
Douglas	Charles W. Giesen, Superior	Conrad Giesen, Superior
Eau Claire–Dunn–Pepin	W. O. Paulson, Eau Claire	C. M. Ihle, Eau Claire
Fond du Lac	D. J. Twohig, Fond du Lac	D. N. Walters, Fond du Lac
Forest	G. E. Carroll, Laona	O. S. Tenley, Wabeno
Grant	J. D. Glynn, Lancaster	M. W. Randall, Blue River
Green	M. W. Stuessy, Brodhead	F. J. Bongiorno, Albany
Green Lake–Waushara	L. J. Seward, Berlin	Mildred Stone, Berlin
Iowa	W. P. Hamilton, Dodgeville	E. J. Hohler, Mineral Point
Jefferson	A. C. Nickels, Watertown	C. J. Garding, Jefferson
Juneau	C. A. Vogel, Elroy	J. S. Hess, Mauston
Kenosha	W. C. Stewart, Kenosha	G. C. Schulte, Kenosha
La Crosse	C. F. Midelfort, La Crosse	P. V. Hulick, La Crosse
Lafayette	N. A. McGreane, Darlington	Mary P. Gratiot, Shullsburg
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	K. A. Morris, Merrill
Manitowoc	E. C. Cary, Reedsville	E. W. Huth, Valders
Marathon	M. L. Jones, Wausau	A. H. Stahmer, Wausau
Marinette–Florence	H. W. Haasl, Pestigo	K. G. Pinegar, Marinette
Milwaukee	H. H. Huber	D. V. Elconin
	N. J. Wegmann	
	E. L. Bernhart	J. A. Enright
	R. E. Galasinski	W. T. Casper
	T. J. Aylward	A. J. Baumann
	D. F. Pierce, Hales Corners	S. W. Hollenbeck
	Aaron Yaffee	S. K. Pollack
	H. W. Hefke	H. W. Pohle
	C. M. Echols	J. G. Garland
	M. W. Sherwood	L. J. Schneeberger
	J. V. Herzog	J. D. Charles
	M. Q. Howard	L. J. Schwade
	F. E. Drew	Joseph Shaiken
	Norbert Enzer	A. J. Baumann
		W. J. Houghton
	J. W. Fons	E. R. Daniels
	Forrester Raine	H. N. Dricken
	M. C. Borman	J. P. Conway

Society	*Delegates*	*Alternate*
Monroe	J. S. Allen, Norwalk	G. C. Devine, Ontario
Oconto	R. J. Goggins, Oconto Falls	A. F. Slaney, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	R. V. Landis, Appleton
Pierce–St. Croix	C. E. McJilton, River Falls	O. H. Epley, New Richmond
Polk	L. O. Simenstad, Osceola	V. C. Kremser, Amery
Portage	E. E. Kidder, Stevens Point	W. C. Sheehan, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	L. E. Nystrum, Medford
Racine	C. O. Schaefer, Racine	G. N. Gillett, Racine
	G. J. Schulz, Union Grove	E. J. Schneller, Racine
Richland	Geo. Parke, Sr., Viola	Geo. Parke, Jr., Richland Center
Rock	H. E. Kasten, Beloit	W. T. Clark, Janesville
	W. A. Munn, Janesville	R. A. Thayer, Beloit
Rusk	L. M. Lundmark, Ladysmith	Woodruff Smith, Ladysmith
Sauk	Roger Cahoon, Baraboo	J. F. Moon, Baraboo
Shawano	A. A. Cantwell, Shawano	E. E. McCandless, Wittenberg
Sheboygan	P. B. Mason, Sheboygan	J. A. Russell, Random Lake
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	R. S. Hirsch, Viroqua	F. F. Gollin, La Farge
Walworth	E. D. Sorenson, Elkhorn	R. A. Mullen, Burlington
Washington–Ozaukee	Arnold Barr, Pt. Washington	T. D. Elbe, Thiensville
Waukesha	F. J. Woodhead, Waukesha	E. C. Van Valin, Sussex
Waupaca	A. M. Christofferson, Waupaca	F. J. Pfeifer, New London
Winnebago	B. J. Hughes, Winnebago	G. R. Anderson, Neenah
Wood	R. E. Garrison, Wis. Rapids	F. X. Pomainville, Wis. Rapids
Section on Internal Medicine	A. W. Bryan, Madison	F. D. Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	L. A. Copps, Marshfield	K. W. Covell, Racine
Section on Orthopedics	R. P. Montgomery, Milwaukee	L. D. Smith, Milwaukee
Section on Radiology	L. V. Littig, Madison	W. T. Clark, Janesville

The Annual Dinner

HOTEL SCHROEDER **TUESDAY, OCTOBER 5**

5:30 p.m.: **President's Reception—Banquet Room**

All physicians and wives invited to this preprandial hour to meet the honored guests and distinguished speaker.

6:30 p.m.: **Dinner—Crystal Ballroom**

Speaker: H. C. Urey, Ph. D., D. Sc., University of Chicago.
"Social Implications of Atomic Energy"

Citation of new members of "50 Year Club"

HAROLD C. UREY, Ph. D.

Only 450 tickets for this dinner can be sold. You are urged to make your reservations in advance if possible. If any tickets are left at the time of registration they may be purchased at the Registration Desk in the Milwaukee Auditorium on Monday, October 4 and Tuesday, October 5.

See page 795 for advance reservation slip!

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GOLF TOURNAMENT OCTOBER 6: The Wisconsin Medical Golf Association announces its annual tournament, to be held at the Merrill Hills Country Club, Waukesha, October 6. Tournament play will start at noon, and a banquet will be held at 6:30 p.m. Full information and reservations for the banquet can be secured by writing G. R. Love, M. D., Summit Hospital, Oconomowoc.

Society Proceedings

Eau Claire—Dunn—Pepin

Meeting at the Elks Club in Eau Claire on May 24, members of the Eau Claire–Dunn–Pepin County Medical Society heard talks by *Dr. Llewellyn R. Cole* and Mr. C. H. Crownhart, both of Madison. Doctor Cole, who is coordinator of graduate medical education at the University of Wisconsin Medical School, discussed "What the Public Thinks of Its Doctors." Mr. Crownhart, secretary of the State Medical Society, pointed out the "General Problems of Medical Societies."

Dr. Ovid O. Meyer, professor of medicine at the University of Wisconsin Medical School, was the guest speaker at the April meeting of the Society, held at the Elks Club in Eau Claire on April 26. He presented a paper on "Recent Advances in Therapy."

Pierce—St. Croix

The annual picnic meeting of the Pierce–St. Croix and the Polk County Medical Societies was held on July 15 at *Dr. O. H. Epley's* cabin on Half Moon Lake in Polk County. Guests of the two societies were the county judges and legislators from that area.

Waupaca

Dr. Robert Irwin of Milwaukee was the guest speaker at a meeting of the Waupaca County Medical Society when it met at the Elwood Hotel in New London on June 24. Doctor Irwin, who is assistant professor of urology at Marquette University School of Medicine, spoke on "Diseases of the Prostate."

Trempealeau—Jackson—Buffalo

The "Bacteriologic Approach to Chemotherapeutics and Antibiotics" was the subject for a discussion by *Dr. H. W. Harris*, La Crosse, at a meeting of the Trempealeau–Jackson–Buffalo County Medical Society held at the Golf Club in Galesville on July 15. Doctor Harris is associated with the Gundersen Clinic at La Crosse.

Washington—Ozaukee

The Port Washington Country Club was the meeting place for the Washington–Ozaukee County Medical Society on July 22. A discussion of a series of cases of arthritis at Wood was presented by *Dr. J. J. Furlong*, Milwaukee. *Dr. J. W. Rastetter*, also of Milwaukee, discussed the presentation by Doctor Furlong.

Central Wisconsin Society of Ophthalmology and Otolaryngology

Two guest speakers from Mayo Clinic in Rochester, Minnesota, were present at the meeting of the Central Wisconsin Society of Ophthalmology and Otolaryngology at Hotel Eau Claire, Eau Claire, on July 10 and 11. At the dinner meeting Saturday evening, Dr. Hugo L. Bair discussed the "Etiology of Uveitis," and Dr. Clifford L. Lake presented a paper on the "Management of Vasomotor Rhinitis." On Sunday morning Doctor Lake talked on "Mucocele of Accessory Nasal Sinuses," and Doctor Bair expressed his "Comments on Present-Day Eye Surgery." A discussion of the problems of contact lenses was presented by Mr. Al Anderson. On Saturday afternoon a golf tournament was held at the Hillcrest Country Club in Eau Claire.

AMERICAN ASSOCIATION OF BLOOD BANKS TO HOLD FIRST ANNUAL CONVENTION

The American Association of Blood Banks will hold its first annual convention in Buffalo, New York, August 26–28. Headquarters will be at the Statler Hotel.

Among the subjects which will be covered will be immunochemical studies on blood group substances, preservation of blood during transit, substitution transfusion in erythroblastosis fetalis, blood volume in relation to surgery, changes in the blood volume of the recipient after transfusion, transfusion of O blood conditioned with A and B substances, red cell suspension transfusions, the factor of rate of transfusion with particular reference to the intra-arterial route, and the role of liver damage in hemolytic diseases of the newborn. Other subjects for discussion are the ultraviolet irradiation of plasma, antenatal diagnosis of erythroblastosis fetalis in the unborn child and its treatment by exchange transfusions, the mental status of patients recovered from erythroblastosis fetalis, studies of Rh antibodies and genotypes by in vitro hemolytic technics, Rh antibodies and the cryptagglutinoids, routine Rh tests for a transfusion service and a rapid method for detection of anti-Rh substance in human serum.

Dr. Tibor J. Greenwalt, Milwaukee, will speak on Saturday morning, presenting a paper on the "Industrial Relations Program of the Junior League Blood Center of Milwaukee." Donor procurement will also be discussed at that time.

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News Items and Personals

Veteran Doctors Honored by Hospital Group

Drs. George H. Williamson and F. Gregory Connell at testimonial dinner.

The medical staff of Theda Clark Memorial Hospital of Neenah, together with the hospital board of directors, honored two of their own July 15 as a dinner was given at North Shore Golf Club complimentary to *Dr. F. Gregory Connell*, Oshkosh, and *Dr. George H. Williamson*, Neenah. Both men have been practicing medicine for more than fifty years.

Silver trays inscribed with the name of the physician, his years of practice, the date of the dinner, and the names of the hosts were presented to the two men by *Dr. J. P. Canavan*, Neenah, secretary–treasurer of the staff, who was toastmaster. *Dr. C. B. Clark*, Neenah, president of the hospital board, paid tribute to the two servants of health in behalf of the board.

Dr. George F. Forkin, Menasha, in eulogizing Doctor Williamson, said: "Your life exemplifies the fulfilment of the American dream of opportunity. We are cognizant of your integrity and the high order of your ethics as displayed toward your patients and your fellow practitioners, and we congratulate you. Not only are you a good physician, but a good teacher as well, and those who know you best respect you most."

In paying tribute to Doctor Connell, *Dr. T. D. Smith*, Neenah, said: "The real reason why we, his fellow physicians, are gathered here tonight to honor Doctor Connell is not because of his white hair or his red necktie, or because he can discuss politics or religion, or because he is the best story teller in the group. It is not because he invented the world-famed Connell suture or performed the first fundusectomy ever done in man for the cure of peptic ulcer. The real reason we are celebrating this event so joyfully is because down deep in the hearts of several of us present here tonight is a tremendous throbbing gratitude that goes out to him personally because we know full well that we still have an unbroken family because of his service to us personally or to our wives or our children. We honor him because he exemplifies so well the value of personal service, knowledge and skill, coupled with a most unselfish desire to give of his own personal energy and endurance, in order that life and energy may be given to others."

Doctor Williamson, a past-president of the Winnebago County Medical Society, retired several months ago, following fifty-three years of practice in Antigo and Neenah. A graduate of the University of Wisconsin Medical School in 1895, he located in Neenah in 1913, where he has served as chairman of the Neenah Health Council for twenty-two years. He has been associated with Theda Clark Memorial Hospital during his entire practice in Neenah and helped organize the nurses' training school, serving as one of its instructors during the years the school operated. Medical examiner of the Equitable Reserve Association since 1918 and vice-president of the association since 1932, Doctor Williamson has been industrial surgeon for the Kimberly Clark Corporation and local surgeon for the Chicago and Northwestern Railroad. Last October he was made a member of the "Fifty Year Club" of the State Medical Society.

Doctor Connell, who has been consulting surgeon at Theda Clark Memorial Hospital since its beginning, is a past-president of the State Medical Society and last year was the recipient of its Council Award. His father, the late Dr. M. E. Connell, was supervisor of Milwaukee County Hospital, and his mother, also a physician, was superintendent of one of the earliest nurses' training schools in the United States. Doctor Connell, a graduate of Rush Medical College, has practiced for fifty-two years. He served as president of the State Medical Society in 1923 and was councilor of the Sixth Councilor District from 1922 to 1931. He also was made a member of the "Fifty Year Club" last October.

G. F. Burgardt Named Health Commissioner of Wauwatosa

Recently appointed health commissioner of Wauwatosa was *Dr. Gerald F. Burgardt*, former deputy health commissioner of Milwaukee. The doctor, a graduate of Marquette University School of Medicine, took over the position on July 2, succeeding *Dr. Roy Hansen*, who resigned recently. The appointment was made by Mayor W. B. Knuese on the recommendation of a panel of physicians, who selected Doctor Burgardt from a list of ten applicants.

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Doctors Ingersoll Feted on Fiftieth Anniversary

Celebrating the fiftieth anniversary of their graduation from medical school and the fiftieth anniversary of their wedding day, *Dr. and Mrs. Robert Ingersoll* of Plainfield were honored by their friends at a gathering in that community on June 23. The previous week they had attended the golden anniversary reunion of their class at the University of Michigan Medical School, from which they both graduated in 1898. Following a number of years as medical missionaries in India, they took postgraduate studies in London, England. Returning to America, they practiced in Florida and in Madison before locating in Oxford in 1928 and in Plainfield in 1941. In addition to his private practice in Plainfield, Doctor Ingersoll has been associated with his son, *Dr. B. P. Ingersoll*, at the Adams–Friendship Hospital in Adams.

Dr. F. E. Zantow Takes Over Oconto Practice

F. E. ZANTOW

Dr. Forrest E. Zantow, formerly of Reeseville, has taken over the practice of *Dr. C. R. Kwapy* at Oconto while Doctor Kwapy is in Milwaukee serving a year's residence at Milwaukee County General Hospital. Doctor Zantow has been located in Reeseville since his release from military service two years ago. Upon completion of his residency, Doctor Kwapy will specialize in treatment of diseases of the eye, ear, nose, and throat.

Dr. W. G. Rence Assumes Duties at Iowa Hospital

Dr. William G. Rence, who left the department of medicine at Monroe Clinic, Monroe, on June 1, assumed his duties as director of the Sigourney Hospital, Sigourney, Iowa, on August 1. The twenty bed hospital has been under the direction of a physician who is now retiring, and Doctor Rence will succeed him in the operation of the institution. Doctor Rence is a graduate of Rush Medical College, Chicago.

Staff of Lakeland Hospital Names Officials

Dr. N. F. Crowe, Delavan, was recently named president of the staff of physicians at Lakeland Hospital, near Elkhorn. *Dr. J. A. Rawlins*, Elkhorn, is vice-president, and *Dr. H. V. Malin*, also of Elkhorn, secretary-treasurer. The executive committee includes *Dr. H. J. Kenney*, Delavan; *Dr. Dean Jeffers*, Lake Geneva, and *Dr. E. O. Sorenson*, Elkhorn.

Dr. G. E. Miller Attends Postgraduate Course

Dr. George E. Miller, Marshfield, attended the sixth biennial continuation course in otolaryngology at the University of Minnesota Medical School the week of June 28. The doctor is a member of the staff of Marshfield Clinic.

Physicians Named Officials of Coroners' Association

Three state physicians were recently named to official positions in the Wisconsin State Coroners' Association. *Dr. Arthur Teitgen*, Manitowoc, was elected vice-president, and *Drs. George D. Reay*, La Crosse, and *E. L. Tharinger*, Milwaukee were placed on the executive committee. Doctor Reay has been president of the group during the past year.

Dr. M. J. Donohue Honored By Langlade County Medical Society

Members of the Langlade County Medical Society gathered at Young's Night Club in Antigo on June 12 to honor their president, *Dr. M. J. Donohue*, who recently observed his fiftieth anniversary in the practice of medicine. Doctor Donohue, a native of Sheboygan, has practiced in Antigo since 1899, and last year was honored with membership in the Fifty Year Club of the State Medical Society.

A graduate of Northwestern University Medical School, Doctor Donohue established his first practice in Clintonville, moving to Antigo a short time later. For many years he was associated in his medical work with his brother, the late Dr. E. J. Donohue. He has served as chief of staff of Langlade Memorial Hospital since 1933.

In a booklet issued by the Langlade County Medical Society for the occasion, the doctors paid tribute to the doctor with the following words: "We have benefited by his counsel, and have drawn upon the wealth and breadth of his experience. He was always at our call and responded gladly to give us the benefit of his exceptional skill when we were faced with unusual situations in our work. He has always been the peacemaker among us, helping us to re-solve personal grievances that we might have had among ourselves.

"In short, he has been our leader and guide and we can look to him as an example of all that a member of our profession should be."

The Antigo City Council passed the following resolution on June 9, 1948:

"WHEREAS, Dr. M. J. Donohue, a life-long resident of Antigo, has completed fifty years in the active practice of medicine in this Community, during which time he has rendered outstanding and unselfish service;

"Be it resolved, By the Council of the City of Antigo that it is the sentiment of the entire Community that such worthy service is entitled to recognition, and Dr. M. J. Donohue is hereby commended and congratulated for the things he has done and is still doing to relieve human suffering and distress.

"Be it further resolved, That copies of this resolution be forwarded to Dr. Donohue and the Antigo Daily Journal."

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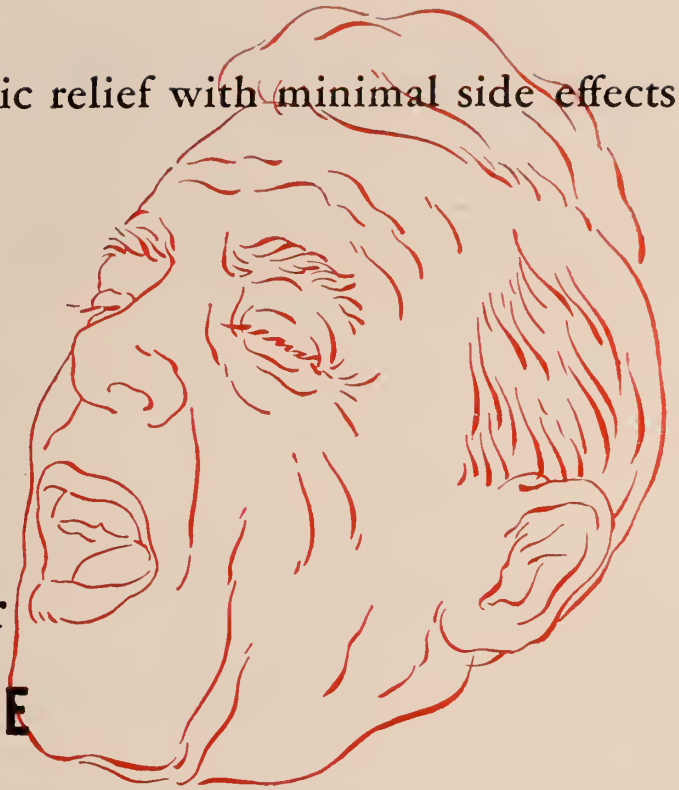

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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. Harold Youngreen Enters Practice in California

A former member of the department of internal medicine at the State of Wisconsin General Hospital, *Dr. Harold Youngreen,* recently moved to Los Angeles, California, where he will become associated in practice with Dr. Stanley Edwards. Doctor Youngreen, a graduate of the University of Wisconsin Medical School, joined the staff of Wisconsin General Hospital in November 1945, following his separation from the Army Medical Corps.

Dr. Hart Van Riper Speaks at Poliomyelitis Conference

H. E. VAN RIPER

Dr. Hart E. Van Riper, medical director of the National Foundation for Infantile Paralysis, Inc. opened the course in infantile paralysis at the University of Wisconsin Medical School on June 28 and was also present to address the dinner meeting in the evening. Doctor Van Riper, formerly a practicing pediatrician in Madison, also served as the general chairman of the first International Poliomyelitis Conference, held in New York City during July. The course presented at the university covered the diagnosis and care of poliomyelitis for the physicians in Wisconsin, and was sponsored by the local county chapters of the National Foundation for Infantile Paralysis in cooperation with the medical School.

Dr. H. B. Haley Reports for Officers Training

First Lieutenant Harold B. Haley, Army Medical Corps, recently reported to the medical field service school at Fort Sam Houston, Texas, for a basic medical department officers course. Before his return to active duty, Lieutenant Haley was a resident surgeon at the Methodist Hospital in Madison.

Dr. Albert Tormey Returns From European Tour

Dr. Albert Tormey, a Madison physician, returned July 12 from a tour of European surgical clinics with his son, who is a senior at the University of Wisconsin Medical School. Making the entire trip by airplane, they visited surgical centers at Dublin, London, Paris, Geneva, and Rome.

TWELFTH DISTRICT NEWS

Dr. E. W. Miller Named President of State Board

Dr. E. W. Miller, Milwaukee, was elected president of the State Board of Medical Examiners at a meeting at Milwaukee on July 1. Doctor Miller succeeds Dr. H. H. Christofferson of Colby, who has been president for the past eight years.

SOCIETY RECORDS

New Members

James J. Leahy, 477 First Avenue North, Park Falls.

Allan D. Hoff, Viroqua.

Morris Moel, 908 North Twelfth Street, Milwaukee.

William E. Braun, Veterans Administration, Wood.

Everett C. Eichoff, Elizabeth Buxton Hospital, Newport News, Virginia.

John H. Steiner, 201 North Main Street, Waupaca.

Changes in Address

J. D. Boland, Mondovi, to N.A.S. Whiting Field, Milton, Florida.

P. C Dietz, Evanston, Illinois, to St. Francis Hospital, La Crosse.

R. H. Barter, Madison, to Gallinger Municipal Hospital, Washington, D. C.

T. J. Beno, Lafayette, Indiana, to Aultman Hospital, Canton, Ohio.

J. B. Cushman, Milwaukee, to Van Nuys Veteran Hospital, Van Nuys, California.

Mae J. O'Donnell, Minneapolis, Minnesota, to 1107 West Dayton Street, Madison.

H. C. Youngreen, Madison, to 676 South Westlake Avenue, Los Angeles, California.

THIRD DISTRICT PHARMACISTS

The pharmacies listed in this section have been recommended as rendering the type of prescription service in keeping with high medical standards.

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J. Frampton Wyman, M. D. Owen C. Clark, M. D.
Hubert H. Blanchard, M. D. John E. Leach, M. D.
Lloyd F. Jenk, M. D.

C. P. Haseltine, Boston, Massachusetts, to 537 Watson Street, Ripon.

L. H. Feiman, Chicago, Illinois, to Jefferson Hillman Hospital, Birmingham, Alabama.

F. E. Zantow, Reeseville, to Oconto.

C. R. Kwapy, Oconto, to Milwaukee County General Hospital, Milwaukee.

E. C. Grosskopf, Milwaukee, to 851 Oakland Avenue, Waukesha.

MARRIAGES

Miss Shirley Ward and Dr. Donald Dieter, Madison, on June 19.

Mrs. Alice Schilling Mould and Dr. Albert W. Bryan, Madison, on June 19.

Miss Dorothy Ann Sauter and Dr. John C. McCullough, North Fond du Lac, on August 7.

DEATHS

A physician portrayed by *Look* magazine in 1943 as the "typical home front doctor," **Dr. Harry A. Keenan**, Stoughton, died at a Madison hospital on July 1. The doctor, who had reached the age of 70 years, had been a lifelong resident of Wisconsin.

Born in the town of Dunn on August 20, 1877, Doctor Keenan attended the University of Wisconsin and Rush Medical College, securing his degree in medicine from the latter in 1903. He served his internship at St. Mary's Hospital, Milwaukee. Prior to his locating in Stoughton, Doctor Keenan practiced at Solon Springs and Edgerton and for a time was a mine surgeon at Roslyn, Washington. During World War I, he served with the Army Medical Corps, receiving his discharge with the rank of captain. In 1930 he was promoted to the rank of lieutenant colonel in the reserve corps.

A former president and member of the executive board of the Dane County Medical Society, the doctor was a member of the State Medical Society and the American Medical Association. He was a member of the American Railway Surgeons and was a company surgeon for the Milwaukee Road. For ten years he had served on the board of trustees of Lakeview Sanitarium, and he was a charter member of the Stoughton Rotary Club. A member of the staff of Stoughton Hospital, the doctor was on the visiting staff of Methodist Hospital, Madison. He also held membership in the Military Surgeons Association and the Reserve Officers Association and was on the Stoughton Public Library Board.

Surviving Doctor Keenan are his wife, a son, and a daughter.

Dr. H. C. Caldwell, retired physician who had formerly been in practice at Ridgeland and St. Croix Falls, died at a Madison hospital on June 24. The doctor, who was 73 years old, had made his home in Madison since his retirement two years ago.

Born July 29, 1874, in Eddyville, Iowa, Doctor Caldwell obtained his medical education at Marquette University School of Medicine, from which he graduated in 1901. His internship was served at Milwaukee County Hospital. He opened his first practice at Ridgeland, and in 1910 moved to St. Croix Falls. In 1944 he joined the staff of the Veterans Administration. During World War I the doctor served with the Army Medical Corps. He retired from active practice in 1946.

Surviving Doctor Caldwell are his wife and two daughters, Dr. Ruth Foster, who is married to Dr. Mark Foster of Madison, and Dr. Esther C. Kurtz, the wife of Dr. Chester M. Kurtz, also of Madison.

Dr. Thomas Arneson, 78, physician at Almena for twenty-five years, died at his home in that community on June 29, following a long illness. He had been in the practice of medicine for more than fifty years.

The doctor was born at Mount Horeb on September 25, 1869. He secured his medical education at Keokuk, Iowa, at the College of Physicians and Surgeons, graduating in 1898. His first practice was established at Florence, Minnesota. Later he practiced at Cumberland and at Canada, Minnesota. During World War I he served with the Army Medical Corps, receiving a citation for the highest patient recovery record of all Army hospitals. He located in Almena in 1923, where he continued practice until his death.

A member of the Fifty Year Club of the State Medical Society, the doctor had been granted affiliate membership with the Society early this year. He was a member of the Barron–Washburn–Sawyer–Burnett County Medical Society and the American Medical Association.

Doctor Arneson is survived by his wife and a son.

MEDICAL EDITORS AND WRITERS TO MEET AT SPRINGFIELD, ILL. ON SEPT. 29

The fifth annual meeting of the Mississippi Valley Medical Editor's Association will be held at the Hotel Abraham Lincoln, Springfield, Ill., on September 29. Dr. Vincent T. Williams, president, of Kansas City, Mo., who is editor of the *Jackson County Medical Society Weekly Bulletin*, will preside. In the afternoon, Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, will give a course in medical writing.

This will probably be the last meeting under the above name, as the purpose of the association will be enlarged and its constitution revised. All ethical physicians and those interested in medical writing are cordially invited. Non-members will be charged a small fee for the afternoon course in medical writing. There is no registration fee for the evening session. For a complete program, write Harold Swanberg, M. D., Secretary, W. C. U. Building, Quincy, Ill.

There'll be fewer sleepless nights this season

BY JULIO DE DIEGO

THE INTRODUCTION of Abbott's new antihistaminic, THENYLENE Hydrochloride, means that more allergic persons than ever before will be working, playing, sleeping in greater comfort. Some hay fever patients will be symptom-free; others will experience relief to a lesser degree. Side-effects will be limited.

In a series of 112 patients with seasonal hay fever (including pollinosis caused by trees, grass, weeds and molds) it was reported that 70 percent were benefited following treatment with THENYLENE Hydrochloride. From a number of independent investigators come reports on various allergies treated with THENYLENE: in a total of 695 such cases, 67 percent were benefited. A significant number of patients in one test group who received several different antihistaminics, reported a better tolerance for THENYLENE, with fewer side-effects.

While no harmful effects have been reported, a total daily dose exceeding 400 mg. (0.4 Gm.) is not recommended, nor continuous use of the new drug beyond eight weeks.

If you would like to try this new antihistaminic, just drop a line to Abbott Laboratories asking for your professional sample and descriptive literature. Or ask your pharmacist—he has THENYLENE Hydrochloride in sugar coated tablets of three sizes, 25 mg., 50 mg. and 0.1 Gm. in bottles of 100, 500. ABBOTT LABORATORIES, North Chicago, Ill.

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1. Feinberg, S. M., Bernstein, T. B. (1947), Histamine Antagonists, VIII. N-(α-Pyridyl)-N-(α-Thienyl)-N', N'-Dimethylethylenediamine, a New Antihistaminic Compound. Experimental and Clinical Experiences, J. Lab. & Clin. Med., 32:1370, November. 2. Feinberg, S. M. (1947), The Antihistaminic Drugs, Amer. J. Med., 3:560, November.

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(ORGANIZED 1929)

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Mrs. M. Q. Howard, Wauwatosa, President-elect
Mrs. N. A. Hill, Madison, Vice-president
Mrs. E. J. Schneller, Racine, Recording Secretary
Mrs. J. C. Fox, La Crosse, Immediate Past-president
Mrs. R. M. Kurten, Racine, Parliamentarian
Mrs. E. H. Federman, Horicon, Corresponding Secretary
Mrs. J. P. Graves, Kenosha, Treasurer

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Archives—
Mrs. R. S. Fisher, Allenton

Finance—
Mrs. H. A. Heise, Milwaukee

Hygeia—
Mrs. E. P. Bickler, Milwaukee

Philanthropic—
Mrs. C. J. Smiles, Ashland

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Mrs. C. N. Neupert, Madison

Program—
Mrs. L. C. Gardner, Fond du Lac

Public Relations—
Mrs. J. M. Johnson, Ripon

Legislation—
Mrs. C. K. Schubert, Madison

Circulation of Bulletin—
Mrs. H. W. Kleinschmit, Oshkosh

Organization—
Mrs. L. H. Lokvam, Kenosha

Postwar Planning—
Mrs. J. W. MacGregor, Portage

Convention—
Mrs. A. J. Randall, Kenosha

Fond du Lac

At the April meeting, Mrs. Ronald W. Steube was elected president of the Auxiliary to the Fond du Lac County Medical Society. Other officers include Mrs. E. V. Smith, Jr., vice-president; Mrs. J. C. Devine, secretary; and Mrs. R. W. Waffle, treasurer.

Plans were completed for a luncheon May 27 at the Wisconsin Home for Women at Taycheedah. This will be a joint meeting with the Dental Auxiliary and the Auxiliary to the Winnebago County Medical Society.

A donation was voted the cancer control fund by the group.

La Crosse

The March meeting of the Auxiliary to the La Crosse County Medical Society was held at the Nurses Home, St. Francis Hospital, on March 31. Member of the board served as hostesses.

The Auxiliary had as its guests representatives from all the parent–teacher organizations in the La Crosse schools. The feature of the meeting was a discussion of the "Child Guidance Clinic," given by Miss Minnetly Spain, county probation officer.

Mrs. Robert Gray gave a report on the silver anniversary drive for *Hygeia*. Subscriptions previously obtained have been increased.

Sauk

Mrs. A. W. Hammond, president of the Auxiliary to the State Medical Society was guest of the Auxiliary on April 20 at the Silver Room of the Warren Hotel in Baraboo. Mrs. Hammond gave an inspiring talk and was presented a box of handkerchiefs by the group.

Mrs. John A. Booker of LaValle entertained the Auxiliary at her home for a 1 o'clock luncheon on May 11.

The following officers were elected: Mrs. J. J. Rouse, of Reedsburg, president; Mrs. C. R. Pearson of Baraboo, president-elect; and Mrs. O. V. Pawlisch of Reedsburg, secretary and treasurer.

Winnebago

Election of officers of the Auxiliary to the Winnebago County Medical Society was held at a family picnic June 9 at the Winnebago State Hospital Park. The following slate was chosen: president, Mrs. R. C. Brown, Neenah; vice-president, Mrs. David Regan, Neenah; president-elect, Mrs. Earl Cummings, Oshkosh; secretary, Mrs. John Nebel, Menasha; treasurer, Mrs. Fred Smith, Neenah; and directors Mrs. William Hildebrand, Menasha and Mrs. R. H. Bitter, Oshkosh.

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Pharmaceutical News for Physicians

Every three months the Wisconsin Pharmaceutical Association will present two pages in The Wisconsin Medical Journal of Pharmaceutical news which will be of interest to Wisconsin physicians.

NEW PRODUCTS — Pharmacists complain of the increasing duplication of products in the pharmaceutical field. The multiplicity of brands of any one product which appear on the market almost simultaneously presents a serious inventory problem for the pharmacist. Taking into account in addition the numerous variations or specialties which inevitably appear around a new drug, the pharmacist may discover that he has on his shelves as many as a dozen packages of what is essentially the same drug or substance.

Some pharmacists attempt to solve this problem by limiting their stock through various means. Some stock only the better known manufacturers' brands of a product—those whose products acceptance by the doctor can be assured in advance.

Other pharmacists stock only the brands or trade names that are being promoted or detailed aggressively to the medical profession in their community. These pharmacists recognize that a certain product may not be "pushed" as effectively by a pharmaceutical house with hundreds of other products in its catalog, as it may be by the smaller company where it is a specialty or one of only a limited "line."

However, a pharmacist will always stock an item that is in demand. He recognizes the economic importance to him of a well-accepted brand or trade name. Even though duplication may occur, no business-like pharmacist will fail to stock each brand or trade name that is in regular demand by physicians.

PRESCRIPTION SURVEY — Dr. E. L. Cataline and Dr. W. T. Bidwell, of the College of Pharmacy, University of Michigan, in the *Bulletin of the National Formulary Committee*, March-April, 1948 reported on a recent study of 7,420 new prescriptions dispensed in three drug stores in Ann Arbor, Michigan.

The authors found that no prescriptions were written in what could be classified as Latin. Even in those in which the titles of ingredients were obvious abbreviations of the Latin titles, the directions were written either in English or partly in English and partly in Latin abbreviations.

They comment that these findings are similar to those of Burlage in a previous survey and support the policy of the U. S. Pharmacopoeia and the National Formulary in giving the English titles of official substances the place of prominence in the monographs.

The 15 most frequently used ingredients in descending order of frequency were the following:

Sulfadiazine, tab., sod. bicarb. tab., codeine phosphate, phenobarb. tab., cosanyl, phenobarb. elixir, thyroid tab., codeine sulfate, ammon. chlorid., salicylic acid, nembutal caps., sulfathiazole oint., empirin comp. tab., cheracol, and seconal sod. pulv.

The authors note that nine of these 15 ingredients must be considered as primarily symptomatic remedies.

AEROHALOR FOR PENICILLIN — There is now available a plastic powder inhaler, known as an Aerohalor, with which Penicillin is delivered as a fine powder and can be applied topically at the point of infection in the upper and lower respiratory tract. It can be used in all conditions where inhalation methods of penicillin therapy have been reported effective, such as bronchiectasis or lung abscess, or penicillin susceptible infections of the upper and lower respiratory tract.

The advantages of this type inhalor are:

1. Simplicity of equipment, no oxygen tanks, valves, tubes, etc.
2. Patient can administer inhalation therapy very easily by nose or mouth.
3. Equipment easily cleaned.
4. About five to ten minutes are required to inhale contents of one sifter cartridge, 100,000 units of penicillin.

Contraindications are the same as for other Penicillin therapy. Care should be taken not to exhale into the inhalor and no food or drink should be consumed for at least an hour after inhalations.

PENICILLIN DUST BENEFITS DISEASES OF NOSE, LUNGS — Inhalation of penicillin and other drugs as a fine, dry, dust is particularly efficacious in diseases of the respiratory tract, according to Dr. George V. Taplin, and Dr. Fred A. Bryan, U.C.L.A. Medical School.

This method is simple, economical, eliminates injection and can be self-administered effectively and painlessly, they report in the *Annals of Allergy*, 1:42, 1948.

The doctors are investigating the results of inhaling various finely-divided antihistaminic drugs, vasoconstrictors and powdered cough mixtures. The preliminary results have been better than anticipated, they report.

With penicillin, organisms sensitive to that drug were nearly always eliminated from the throat and sputum in a few days. Mixtures of penicillin and streptomycin removed practically all bacteria from the respiratory tract temporarily.

A micronized antihistaminic, alone or mixed with vasoconstrictors, was effective in relieving symptoms of asthma and hay-fever. The relief usually lasted one to eight hours after inhalation of one-twentieth to one-tenth the usual dose by mouth.

ORAL PENICILLIN IS FOUND EFFECTIVE IN 350 CASES — Oral administration of penicillin appears to be as effective in combating infections as the intramuscular route, according to a report by Doctors Jay A. Robinson, Harold L. Hirsch, and Harry F. Dowling, of the George Washington University and Georgetown University Medical Divisions, here.

The physicians state, in *The American Journal of Medicine*, 4:716, 1948, that the results of administering penicillin orally to 350 patients with various infections closely approximated the results of those obtained in over 600 patients treated with intramuscular injections.

The oral doses used in this series were approximately five times as great as the parenteral doses.

Hypersensitivity reactions were less frequent with penicillin given by mouth than by the other commonly-used methods, they point out. In addition, "The simplicity of the oral administration of penicillin makes it one of the more desirable methods of administration."

The results of the present series showed that the effectiveness of oral penicillin was comparable to parental therapy in the case of pneumonia, streptococcic sore throat, scarlet fever, erysipelas and otitis media.

METHIONINE HELPS HUMAN CIRRHOSIS — An editorial in the *Journal of the American Medical Association* for April 3, directs attention to a recent study which indicates a favorable action of dl-methionine upon patients with cirrhosis of the liver.

The Journal points to this study because a report of the Council on Pharmacy and Chemistry in January 1947 on the possible role of methionine in liver injury had stressed that experimental dietary cirrhosis seen in animals is not histologically the same as portal cirrhosis in man and asserted that experiments reviewed up to that time required clinical confirmation on human patients.

The recent study which supplies clinical data is by A. J. Beams and E. T. Endicott, and was published in *Gastroenterology* 8:718, 1947.

THERAPY WITH VITAMINS C AND K HELPS CHECK CHRONIC NOSEBLEEDS — Sufferers from chronic nosebleeds may often be helped by ascorbic acid and vitamin K, it is indicated by recent studies at the New York Presbyterian Hospital.

In 104 cases of chronic nosebleed, a high percentage of people with low blood vitamin C was found. In these same people there was also a high percentage whose prothrombin time was low, and indication of low blood vitamin K.

These disclosures are made by Dr. Harry Neivert and Dr. Recha Engelberg, of New York, and Dr. Leo Fink, of Hoffman-La Roche, Inc. They report in the *Archives of Otolaryngology*, 47:37, 1948.

The effect of treating these individuals with chronic nosebleeds with vitamins C and K was determined in 36. Of these, 27 were said to be definitely improved.

There were 26 other patients who were given the treatment but who failed to report back to the clinic for evaluation of results. However, since many of these had formerly come to the clinic repeatedly for nose bleed, their absence suggests that they derived some benefits from the vitamins, the investigators point out.

They describe one case suffering from repeated daily nasal hemorrhages. Although the ascorbic acid blood value was normal, the prothrombin was low. Administration of a vitamin K preparation controlled the tendency to have nosebleeds.

The patient was later advised to substitute liberal amounts of green salad and vegetables (sources of vitamins C and K) for the drug, and he continued to remain free of nosebleeds.

GLUTAMIC ACID — Glutamic Acid (l (+) glutamic acid) is a non-toxic amino acid which tends to improve physical and mental alertness. It is prepared from natural sources by acid digestion or hydrolysis of vegetables and animal proteins. The dose ranges from twelve to twenty-four grams per day in three divided doses. Since there is no apparent relationship between weight, age, and dosage, the proper dosage must be established in each case. Clinicians usually start with a dose of four to six grams daily and gradually increase the amount to the point of improved mental and physical activity. Beneficial effects develop rather slowly, generally over a period of several months.

PYRIBENZAMINE AIDS TREATMENT OF MORPHINE ADDICTION — Pyribenzamine seems to aid in the treatment of morphine addiction by alleviation of the symptoms which occur when the narcotic is withdrawn. Kells reports one case in *South. Med. J.* (41:134(1948)) in which this action of the anti-asthmatic drug was noticed accidentally. In the case cited pyribenzamine was being given spasmodically for attacks of asthma. It was noticed that the morphine withdrawal symptoms were less severe when pyribenzamine had been given. The patient then was given 50 mg. of pyribenzamine 4 times a day. By the end of two weeks the patient was able to go without morphine for 72 hours. Shortly thereafter both drugs were withdrawn and the patient has remained free from addiction. The author suggests that an antimorphine substance is generated by the body during morphine addiction, which causes the typical withdrawal symptoms. Pyribenzamine is believed to neutralize this substance chemically and thus eliminate the withdrawal symptoms.

ASPIRIN MAY CAUSE ASCORBIC EXCRETION — The urinary excretion of vitamin C may be significantly increased following ingestion of aspirin in the presence of virus infections, state Dr. J. M. Spitzer and Dr. Shepard Shaprio.

The physicians, who are with the Goldwater Memorial Hospital and Willard Parker Hospital, New York, advise that vitamin C should therefore be administered simultaneously with salicylates.

They describe investigations on both children and adults. In one child, aspirin caused a slight increase in urinary excretion of ascorbic acid. During the test the child became ill with an acute respiratory infection association with fever. Aspirin was administered in doses of 2 gms. on the first and second days. The vitamin C excretion increased sharply from the normal range of 20-30 mg. to 32 mg. the second day, 112 mg. the third, and fell back to 54.2 and 56.1 the two succeeding days.

A group of 11 children recovering from acute contagious diseases was studied in similar fashion, and all showed increased loss of vitamin C after aspirin therapy, the doctors state. They point out that the elevated elimination of vitamin C bore no relation to the body temperature.

The investigators, writing in the *American Journal of Digestive Diseases*, 15:80, 1948, discuss the occurrence of hemorrhages during rheumatic fever. They suggest that a vitamin C deficiency may be implicated in the process, due to the massive salicylate medication. Therefore they recommend administration of both vitamin C and K simultaneously with salicylates.

The purpose of the vitamin K is to prevent a lowering of the blood prothrombin time.

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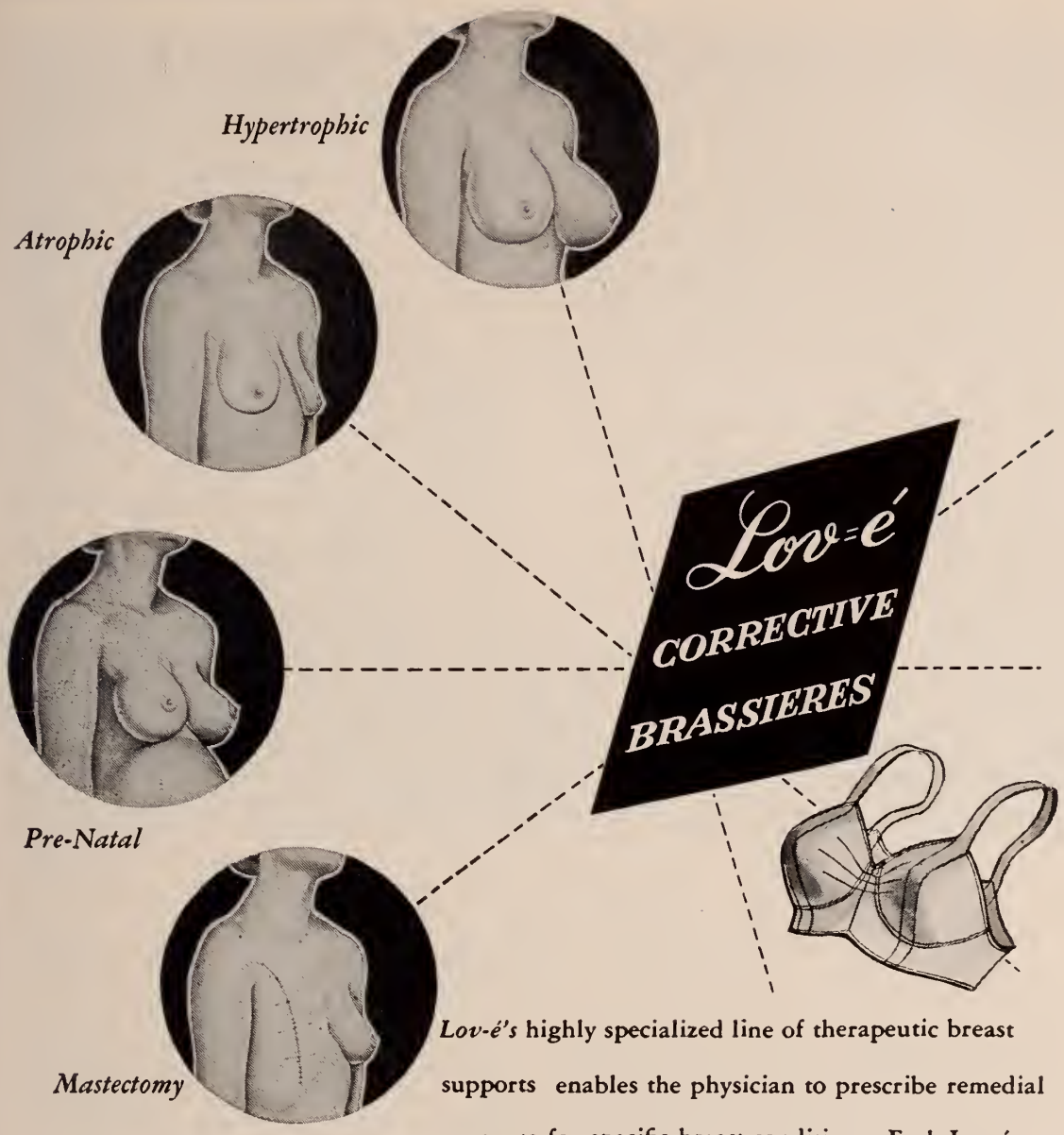

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Heart; A Physiologic and Clinical Study of Cardio-Vascular Diseases. By Aldo A. Luisada, M. D., Instructor in Physiology and Pharmacology, Tufts College Medical School; Lecturer in Medicine; Lecturer, Postgraduate Division, Tufts College Medical School; Associate in Medicine, Beth Israel Hospital, Boston, Massachusetts; Former Professor of Medicine, Ferrara, Italy. With a Foreword by Herrman L. Blumgart, Physician-in-Chief, Beth Israel Hospital; Professor of Medicine, Harvard Medical School. Pp. 653. Baltimore: The Williams and Wilkins Company, 1948. Price: $10.00.

This reference work on cardiovascular disease is unique in many respects. The first chapter consists of an outline of the history of cardiology from the year 1500 to the present. The next two chapters deal with the detailed development, anatomy, and physiology of the cardiovascular system. The remainder of the book is devoted to the clinical aspects of diseases of the circulatory system, including an excellent chapter on peripheral vascular disturbances. The author has obviously spent much time in the experimental laboratory and employs this experience to provide a substantial physiologic foundation for the clinical discussion of each subject presented. Graphic methods with special emphasis on the phonocardiogram are stressed in connection with the clinical examination. Diets and other aspects of the treatment of hypertension, congestive failure, arrhythmias, and cardiac emergencies are presented in detail, and for the most part represent the best current thought although one must take exception to the recommendation of intravenous mecholyl in auricular tachycardia (p. 79) and intravenous digoxin for ventricular tachycardia (p. 314). The chapter on congenital defects is particularly well done, and there is a comprehensive and practical outline of our present knowledge of the digitalis glycosides. This volume presents a new, interesting, and practical approach to the subject of cardiovascular disease and can be recommended to the general practitioner as well as to the internist and cardiologist.—C. M. K.

Rypins' Medical Licensure Examinations; Topical Summaries, Questions, and Answers. Edited by Walter L. Bierring, M. D., F. A. C. P., M. R. C. P., Edin. (Hon.); Former Member, National Board of Medical Examiners; Former Member, American Board of Internal Medicine; Former Member, Iowa State Board of Medical Examiners; Professor Emeritus, Theory and Practice of Medicine, College of Medicine, State University of Iowa; Secretary, Federation of State Medical Boards of the United States, With the Collaboration of a Review Panel. Sixth Edition. Pp. 690. Philadelphia and London: J. B. Lippincott Company, 1947. Price: $6.00.

This is an interesting and authoritative book, now in its sixth edition with fifteen years' experience back of it. As a guide, it will be of help to the medical examiner, and to the examinee it will serve to give him a better perspective for his forthcoming examinations. Although not a text for the medical student, it will serve as a guide in review and preparation for examination.

The book is divided into two parts, the first being on Basic Medical Sciences and the second on Clinical Sciences. The last two editions have had new sections added, first on pharmacology in the fifth edition, and a section on psychiatry in the sixth.

In its compactness and orderliness of presentation, it should help the recent graduate in the arrangement of his medical knowledge, and it is therefore to be highly recommended.—K. L. P.

Nursing in Modern Society. By Mary Ella Chayer, R. N., A. M., Associate Professor of Nursing Education, Teachers College, Columbia University. Pp. 288. New York: G. P. Putnam's Sons, 1947. Price $4.00.

This book might be considered as one answer to the perplexing question, "In what direction shall nursing go?" Miss Chayer says in the foreword, "Nursing of the future must be regarded as one important aspect of our social structure that exerts a social force at the same time that it is being acted upon by social forces."

The subject matter is organized in three parts, "The Impact of Social Forces Upon Nursing," "The

The First Narcotic . . .

Medicine and Dentistry thank a young Prussian drug clerk, Friedrich Sertürner (1784-1841), for isolation of the first pure alkaloid of opium, morphine—named for Morpheus, god of Dreams, son of Somnus, god of Sleep.

A physician's lament over the unreliability of opium prescriptions spurred Sertürner to a 15-year search for the secret locked in the juices of the poppy plant. His addition of ammonia to an opium solution in 1806 caused a formation of gray crystals, from which he succeeded, in 1816, in wresting the real *principium somniferum*—morphine itself.

In its wake have come not only all the barbiturates and milder anodynes, but also many alkaloids isolated by methods similar to Sertürner's: heroin, emetine, quinine, vertabrine, strychnine, etc.—pure, dependable drugs bringing new standards to medicine and dentistry.

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Influence of Social Forces Upon Community Health Needs," and "Building a Better Future."

To all who are interested in the education and practice of nurses, part three, "Building a Better Future," is thought provoking. Revolutionary changes, rather than patching are suggested for nursing school curricula. Present day curricula have not succeeded in preparing the nurse for her "place which must be defined within the larger pattern of community life." Ways are pointed out for utilizing the services of nurses so that nursing may act effectively as a social force which has a goal of "better health for every dweller in America, and more and better nursing care for the persons who need it most." In an interesting chapter dealing with "Emerging Patterns of Nursing Education," the two year, three year, and collegiate plan for preparing nurses is discussed. Miss Chayer suggests that it might be possible to define a "generic base" upon which all nursing education depends. The entire curricula of nursing education might then be considered as a "series of graduated steps toward higher levels of competence."

The book could profitably be read by the general public. It should be read by all nurses because of the great challenge it presents. Miss Chayer says, "Society has arrived at a sufficiently clear understanding of its need for nursing for it to give the profession a chance to choose the 'high way or the low'."—M. E.

Treatment in General Practice. By Harry Beckman, M. D., Professor of Pharmacology, Marquette University School of Medicine, Milwaukee, Wisconsin. Sixth Edition. Pp. 1129. Philadelphia and London: W. B. Saunders Company, 1948. Price: $11.50.

The pace at which medicine is advancing in our time has obliged the preparation of successive editions of this book at progressively shortening intervals, observes Dr. Harry Beckman in the preface of this sixth edition of his excellent text. Such a statement, although definitely pertinent, nevertheless is remarkably conservative in view of the ability of the author to fulfill such an obligation. This revision appears only two and one-half years after the previous publication, with the added promise of their being succeeding revisions in an even shorter interval.

To keep pace with advancements in certain special phases of medicine usually proves quite a task. Thus, the ability of the author to do so for the entire broad field of therapeutics is even more remarkable. Evidence of the ability is the inclusion for the first time of material concerning nineteen new diseases or clinical conditions, such as Colorado tick fever, newly differentiated anemias, management of penicillin reactions, and thrombosis and embolism.

Many practitioners have found that "Treatment in General Practice" has filled a gap which existed in their formal medical education and have wel-

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Practical Bacteriology, Hematology, and Parasitology. By E. R. Stitt, M. D., Ph. M., Sc. D., LL. D., Rear Admiral, Medical Corps, and Surgeon General, U. S. Navy, Retired; Paul W. Clough, M. D., Physician-in-Charge of Diagnostic Clinic, Johns Hopkins Hospital; and Sara E. Branham, M. D., Ph. D., Sc. D., Senior Bacteriologist, National Institute of Health. Tenth Edition. Pp. 991, with 765 illustrations. Philadelphia and Toronto, The Blakiston Company, 1948. Price: $10.00.

This book, with its wealth of laboratory information, includes, as do the previous editions, a wider range of subject matter than is implied by the title, for there are chapters on filtrable viruses, rickettsiae, medical mycology, and medical entomology, as well as approximately 200 pages on the examination (mainly clinical chemistry) of various body fluids and organs. The book, then, in reality, is concerned with the general field of clinical laboratory diagnosis.

With the addition of Sara Branham as a co-author, the section on bacteriology has undergone the greatest revision, with the addition of such procedures as the use of hen's eggs for cultivating bacteria, rickettsiae, and viruses and the use of Frobisher's chick test for determining virulence of diphtheria organisms. In the section on bacteriology, however, there is not a systematic arrangement of the chapters; for example, the chapter on medical mycology follows the one on filtrable viruses. Nevertheless, the subject matter within the chapters is well presented.

This carefully edited book is well illustrated, although mainly in black and white, and is a valuable book for those engaged in laboratory work.—G. W.

A Manual of Otology, Rhinology and Laryngology. By Howard Charles Ballenger, M. D., F. A. C. S., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Third Edition, enlarged and thoroughly revised. Pp. 352, with 135 illustrations and 3 color plates. Philadelphia: Lea & Febiger, 1947. Price: $4.50.

"A Manual of Otology, Rhinology, and Laryngology" by Howard Charles Ballenger will serve as an excellent text for the undergraduate student. The

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subject material is well organized, with each disease discussed adequately under subheadings of etiology, diagnosis, anatomy, therapeutics, and prognosis.

Although brief, the material is presented in an accurate and concise manner, without great elaboration. The drawings and photographs are exceptionally well chosen. The important and the common diseases of the specialty are adequately treated. It is indeed gratifying to find such an inclusive coverage in such a small manual.

The book should prove a valuable introduction and text for the undergraduate student and the general practitioner as well.—W. M. N.

A Textbook of Clinical Neurology; With an Introduction to the History of Neurology. By Israel S. Wechsler, M. D., Clinical Professor of Neurology, Columbia University, New York; Neurologist, The Mount Sinai Hospital; Consulting Neurologist, Montefiore Hospital and Rockland State Hospital, New York. Sixth Edition. Pp. 829, with 162 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price: $8.50.

The 1947 edition marks the twentieth anniversary of this "Textbook of Clinical Neurology." Since the first edition, there have been five revisions and reorganizations of the book with the addition of new material enhancing its value. This volume is an accepted textbook for the student of medicine and the general practitioner. The author acknowledges that there has been much "winnowing of the literature" and that the work is based mainly on personal teaching and clinical experience. This has led to the writing of a book which is sound in its presentation of neurologic entities but lacking at times in necessary detail and completeness. The book, as a result, is of less value to the advanced student of neurology.

The reviewer was of the opinion that, in addition to the chapters on the history of neurology and the section on the neuroses, the subject of psychosomatic medicine should have been included in a new edition, presenting the subject from the viewpoint of the neurophysiologist and the neurologist. There are other omissions of a less serious nature such as the failure to consider critically the Sister Kenny treatment of poliomyelitis, rheumatic encephalopathy, and toxoplasmosis, to mention a few examples.—E. P. R.

CORRESPONDENCE

The Medical Society of the District of Columbia

July 8, 1948

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Dear Sir: Just a note to let you know that I have seen the new cover of *The Wisconsin Medical Journal.* I think it is most attractive and a great improvement over the previous one. I especially like the red ink. Of course, you know I have a weakness for red. And I am not a Communist!

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Coming Events

University of Illinois to Offer Postgraduate Course on Cancer of the Oral Cavity

An evening postgraduate course of six lectures designed to present recent advances in cancer of the oral cavity will be offered again by the University of Illinois College of Dentistry, in cooperation with the Illinois division of the American Cancer Society, the Illinois State Dental Society, and the Illinois State Medical Society, beginning October 6. The course will place emphasis on the characteristics and differential diagnosis of oral lesions and will include consideration of public health aspects, cancer research, surgical and radiation treatment, and surgical and prosthetic reconstruction.

Dr. Bernard G. Sarnat, head of the department of oral and maxillofacial surgery of the University of Illinois College of Medicine, will be in charge of the course, which will be offered over a period of six consecutive Wednesdays. The tuition charge for the course has been waived through the courtesy of the Illinois division of the American Cancer Society.

Further information and registration for the course may be obtained by writing Dr. Isaac Schour, associate dean in charge of postgraduate studies, of the college of dentistry, 808 South Wood Street, Chicago 12.

Statewide Conference on Mental Health to Be Held in Madison

The first state-wide conference on mental health in Wisconsin, co-sponsored by the Department of Neuropsychiatry and the Wisconsin Society for Mental Health, will be held at the Memorial Union, University of Wisconsin, Madison, on September 15. Following registration, the morning session will deal with recognizing emotional needs in the home and community and on the job. The afternoon session will treat of handling emotional crises. The sessions will be followed by an evening program of interest. The conference has as its theme, "Wholesome living and peace of mind are the fruits of intelligent planning and cooperation; not the outcome of reliance upon chance." The purpose is to reach the interested intelligent citizen primarily, although it is anticipated that the meetings will attract professional workers and representatives of various organizations throughout the state.

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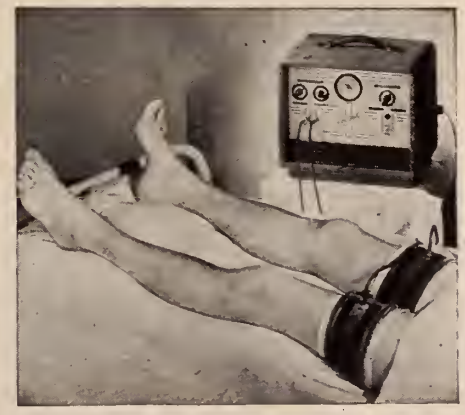

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	817
Audiphone Utilities	831
Ayerst, McKenna & Harrison	758
Barr X-Ray Co.	829
Bellevue Place	831
Benson Optical Co.	749
Bergmann Prescription Pharmacy	815
Borden Co.	750
Camel (R. J. Reynolds Tobacco Co.)	761
Camp, S. H. & Co.	760
Central Drug	823
Ciba	813
Coca Cola Co.	748
Continental Casualty Company	828
Cook County Graduate School of Medicine	813
Doerflinger's	831
Endocrine Laboratories	831
First Central Dispensary	815
Hotel Schroeder	830
House of Bidwell, Inc.	829
Hurley X-Ray Co.	829
Ivanhoe Treatment, Inc.	828
Jensen Brothers	823
Kennedy–Mansfield Dairy	832
Lilly, Eli and Company	facing page 763
Lov-é Brassieres	819
M & R Dietetic Laboratories, Inc.	759
Mallatt Pharmacy	815
Mather Pharmacy	823
Mayer Drug	823
Mead Johnson & Co.	754, 834
Medical Protective Co.	821
Merck & Co., Inc.	835
Milwaukee Optical Co.	824
Milwaukee Sanitarium	836
New World Life Insurance Co.	811
New York Polyclinic	829
Orthopedic Appliance Co., Inc.	831
Parke, Davis & Co.	746, 747
Physicians Casualty Assn.	830
Physicians Radium Assn.	829
Pogue, Mary E., School	818
Prescription Pharmacy	815
Professional Business Service	*Forum* 5
Radium Service Corporation	826
Rennebohm Drug Stores	815
Rentschler Floral Co.	832
Rexall	752
Roemer's	826
Rogers Memorial Sanitarium	836
Sacred Heart Sanitarium	815
St. Croixdale Sanitarium	749
Schering Corporation	751
Schlintz Bros. Drug Store	823
Searle, G. D. & Co.	809
Shorewood Hospital Sanitarium	811
Smith–Dorsey Company	755
Smith, Kline and French	757
Summit Hospital	822
Swift and Company	753
Time Insurance Company	*Forum* 3
Wander Co.	756
Winthrop–Stearns, Inc.	762

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WANTED: General practitioner to take over large practice of doctor who is retiring. Territory is in urgent need of a physician. Address replies to No. 169 in care of the Journal.

WANTED: A combination physiotherapist and x-ray technician for a physician and surgeon's office in Waukesha. Please state age, experience, salary, and availability. Address replies to No. 184 in care of the Journal.

WANTED: Location for general practice or a suitable association with opportunity to limit field to internal medicine or obstetrics and gynecology. Hospital facilities and good living conditions must be available. Address replies to No. 185 in care of the Journal.

YOUNG PHYSICIAN WANTED: Physician with large practice in southern Wisconsin desires to acquire the help of a young physician. Good salary, leading to early partnership. Address replies to No. 177 in care of the Journal.

YOUNG MAN WANTED: Physician with large practice in thriving college town in southern Wisconsin desires young associate. Good salary and assured living quarters. Exceptional opportunity for man with sound basic training. Address replies to No. 144 in care of the Journal.

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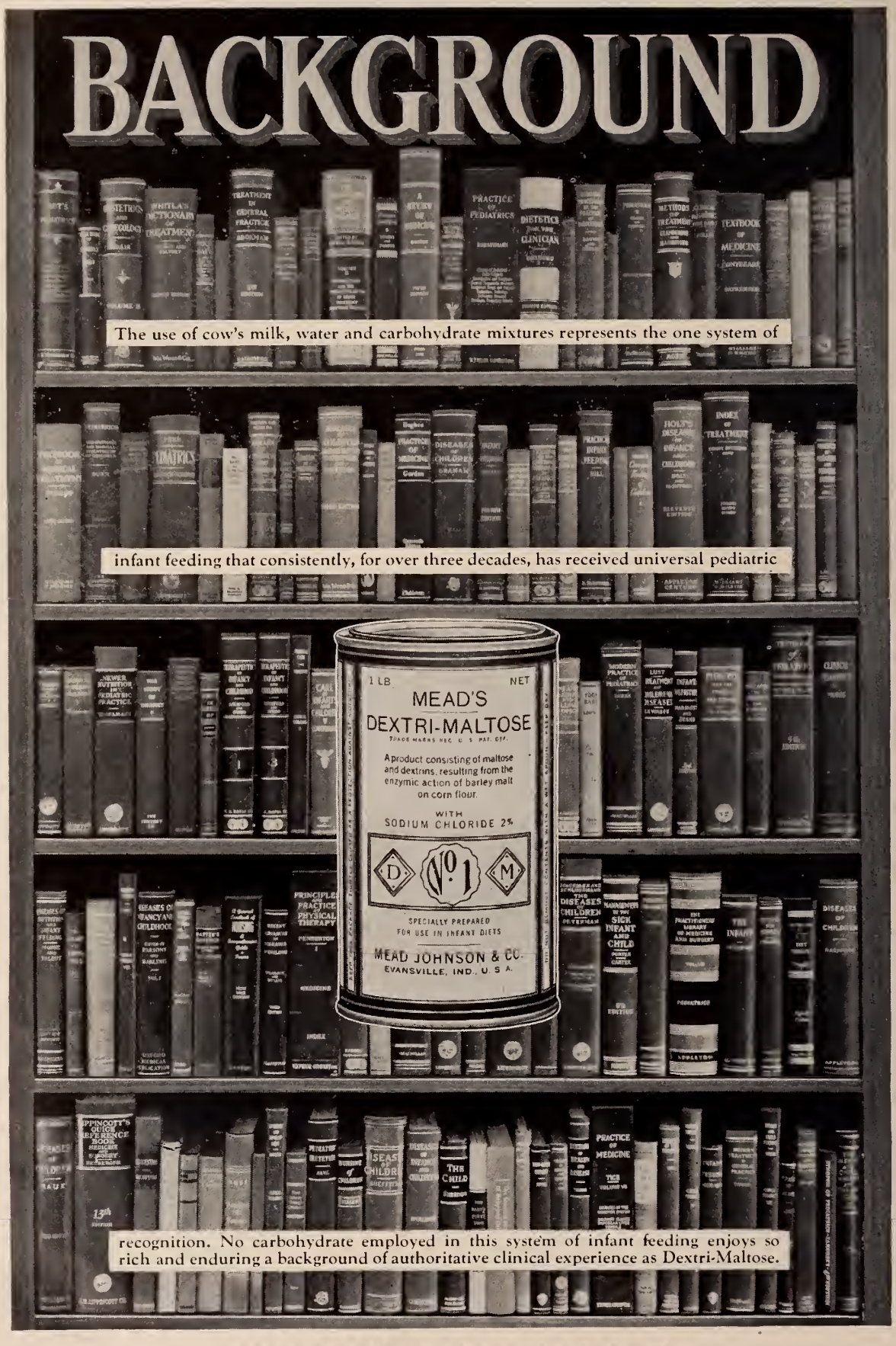
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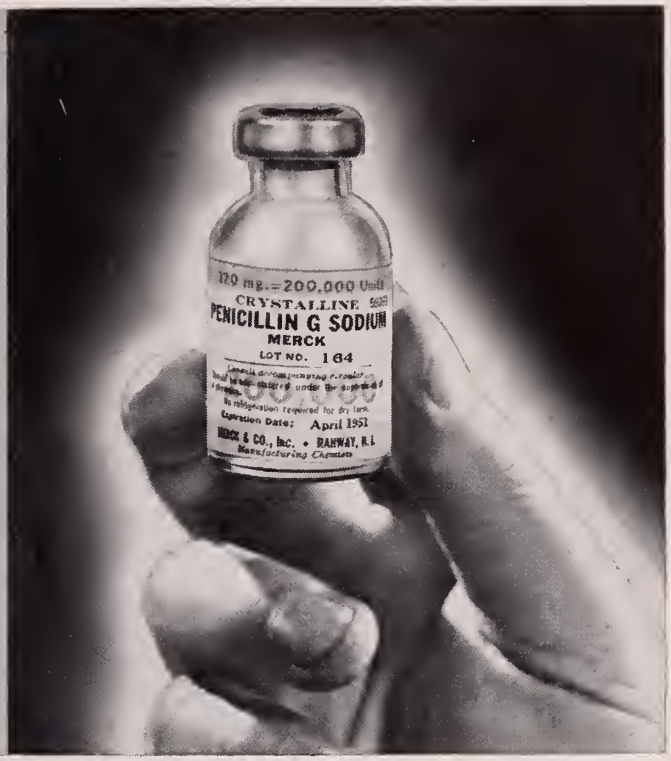

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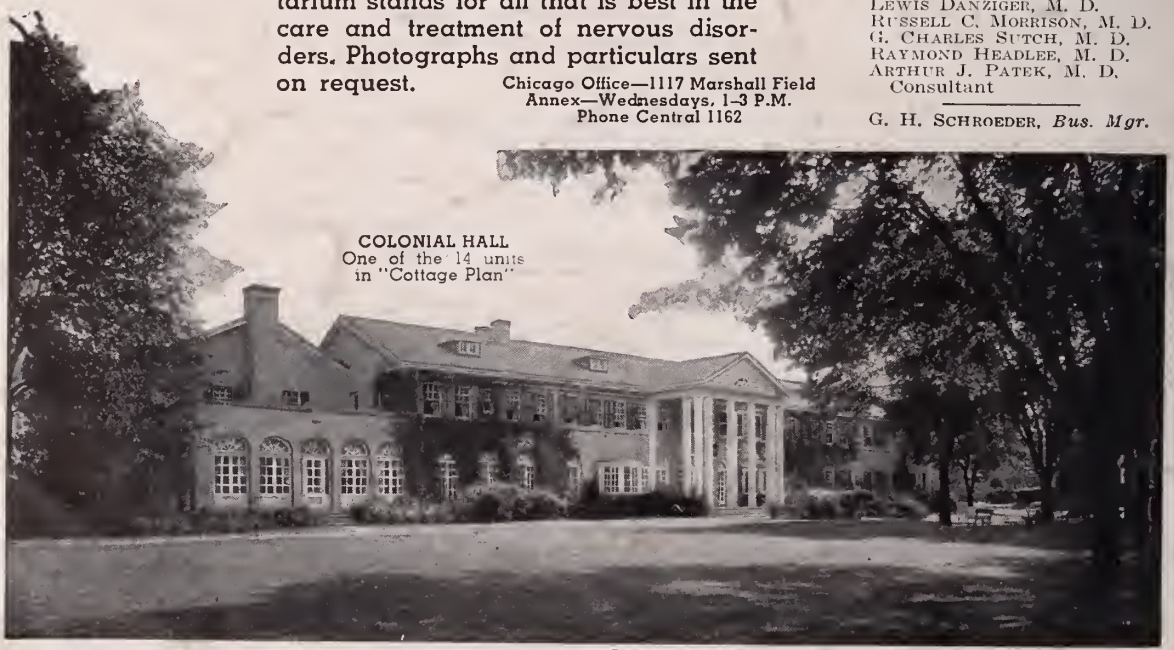

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TABLE OF CONTENTS, PAGE 840

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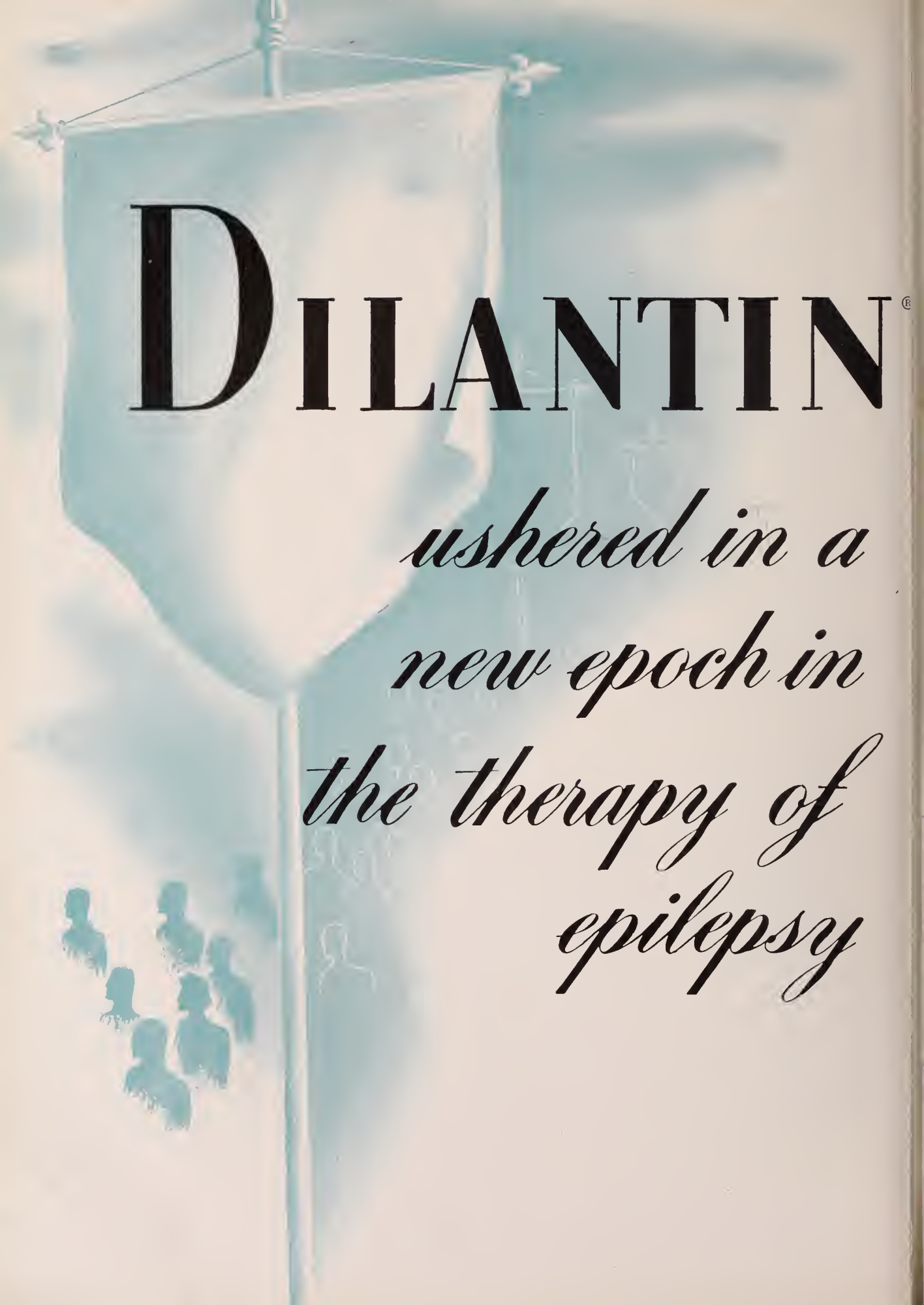
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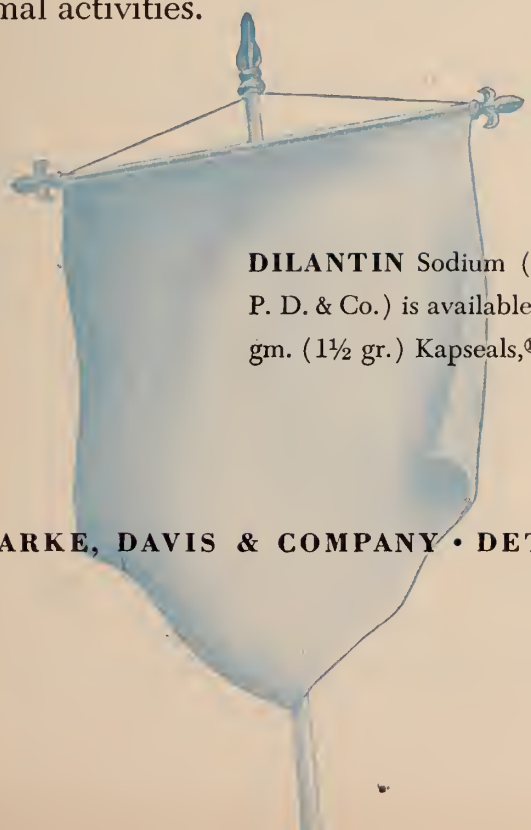

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

Treatment of Raynaud's Disease With Nitroglycerine, by Max J. Fox, M. D., Milwaukee ---- 855

Carcinoma of the Common Bile Duct; Report of a Case, With Discussion, by J. A. Killins, M. D., Green Bay ---- 859

Focal Points in Child Development, by Milton J. E. Senn, M. D., New York ---- 861

Early Schizophrenia Complicated by Rheumatic Fever, by Henry Veit, M. D., Milwaukee ---- 865

Diverticulosis and Diverticulitis of the Appendix, by J. W. Frye, M. D., Milwaukee, and J. B. Miale, M. D., Marshfield ---- 868

Birth, Infant Death, and Stillbirth Data; Wisconsin 1947, by Amy Louise Hunter, M. D., Dr. P. H., Madison ---- 870

Comments on Treatment ---- 875

Notes on Clinical Pathology ---- 876

As It Looks to Your State Board of Health ---- 877

EDITORIAL

Your Cue, Doctor! ---- 878

MISCELLANY

Page

The President's Page ---- 879

Annual Meeting
Official Program ---- 881
Official Notices ---- 882
Timetable ---- 884
The Scientific Cinema ---- 889
Scientific Exhibits ---- 897
Technical Exhibits ---- 900
House of Delegates—1948 ---- 906
Officers of State Medical Society ---- 908
Councilors of State Medical Society ---- 909

Annual Reports of the Officers and Committees to the 1948 House of Delegates ---- 911

Society Proceedings ---- 933

And About the Third and Twelfth Districts ---- 934

Society Records ---- 936

Marriages ---- 936

Birth ---- 936

Deaths ---- 936

A Joint Resolution ---- 940

The Woman's Auxiliary ---- 943

The Journal Bookshelf ---- 948

Physicians' Exchange ---- 962

Index to Advertisers ---- 964

List of Executive Officers of County Medical Societies ---- 965

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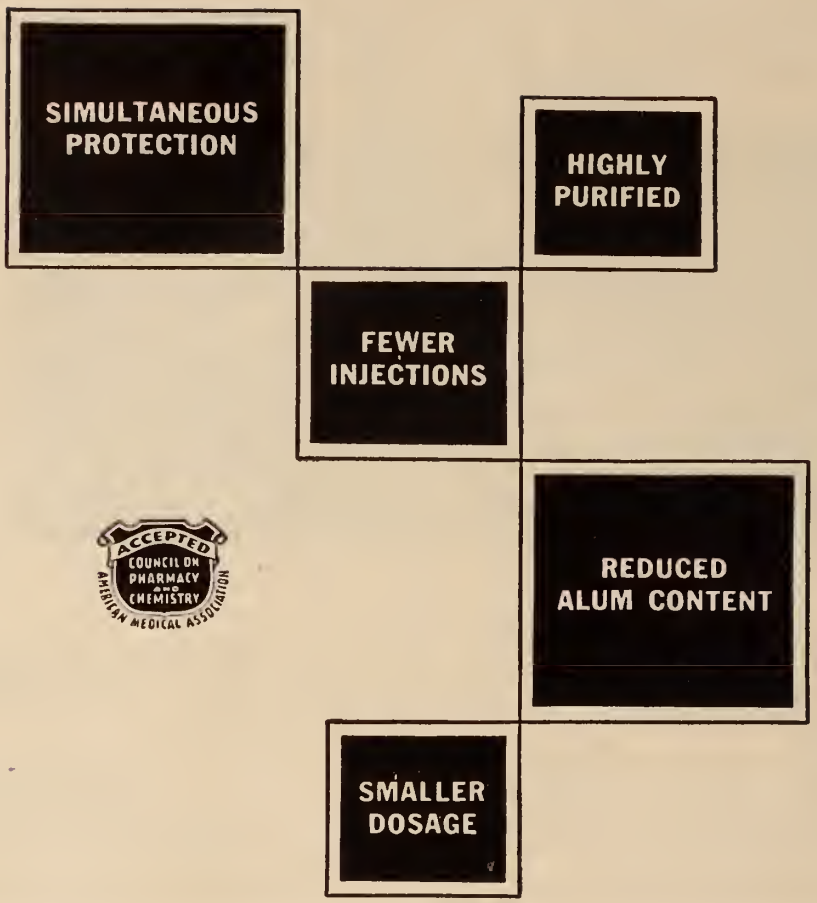

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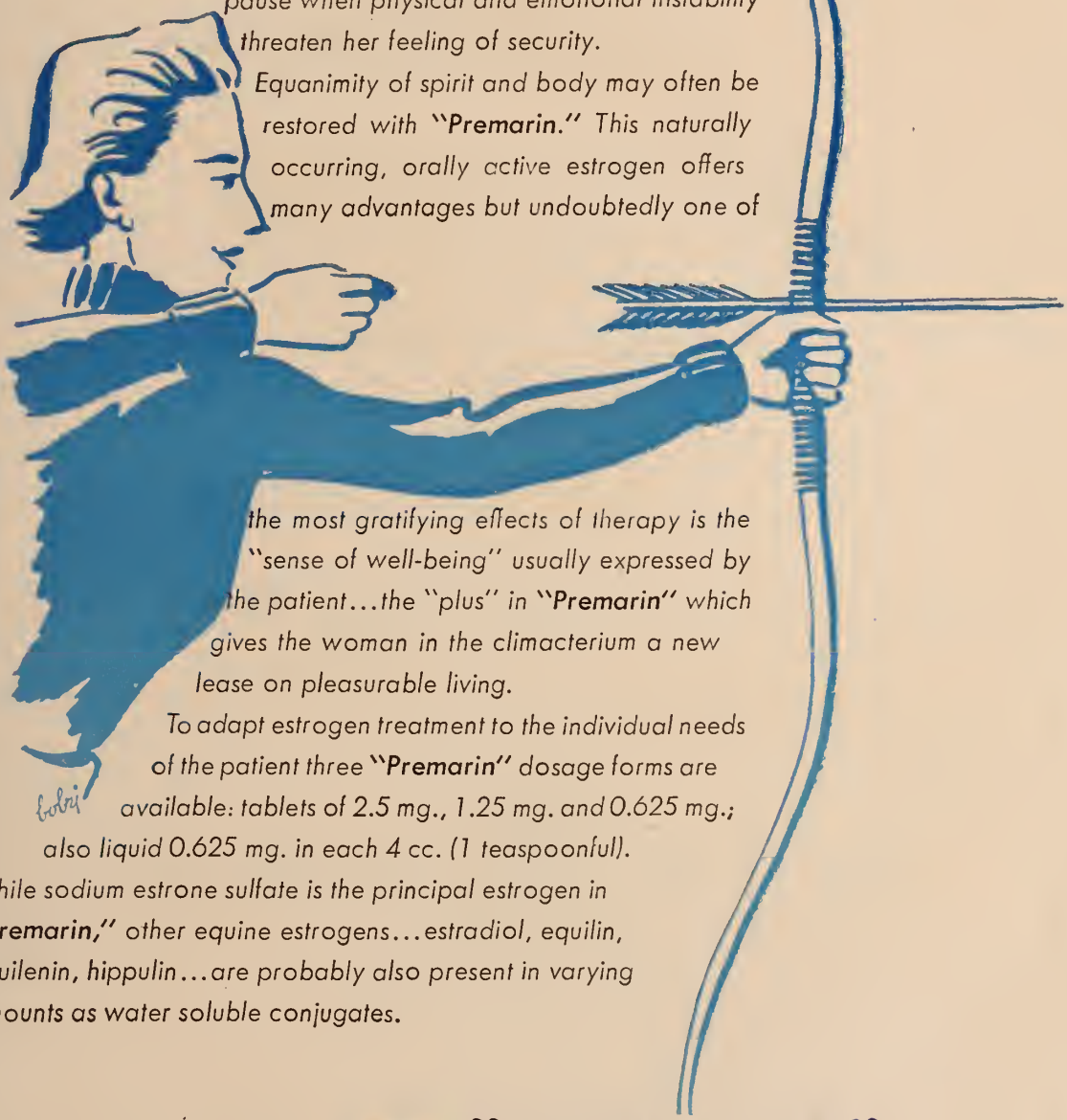

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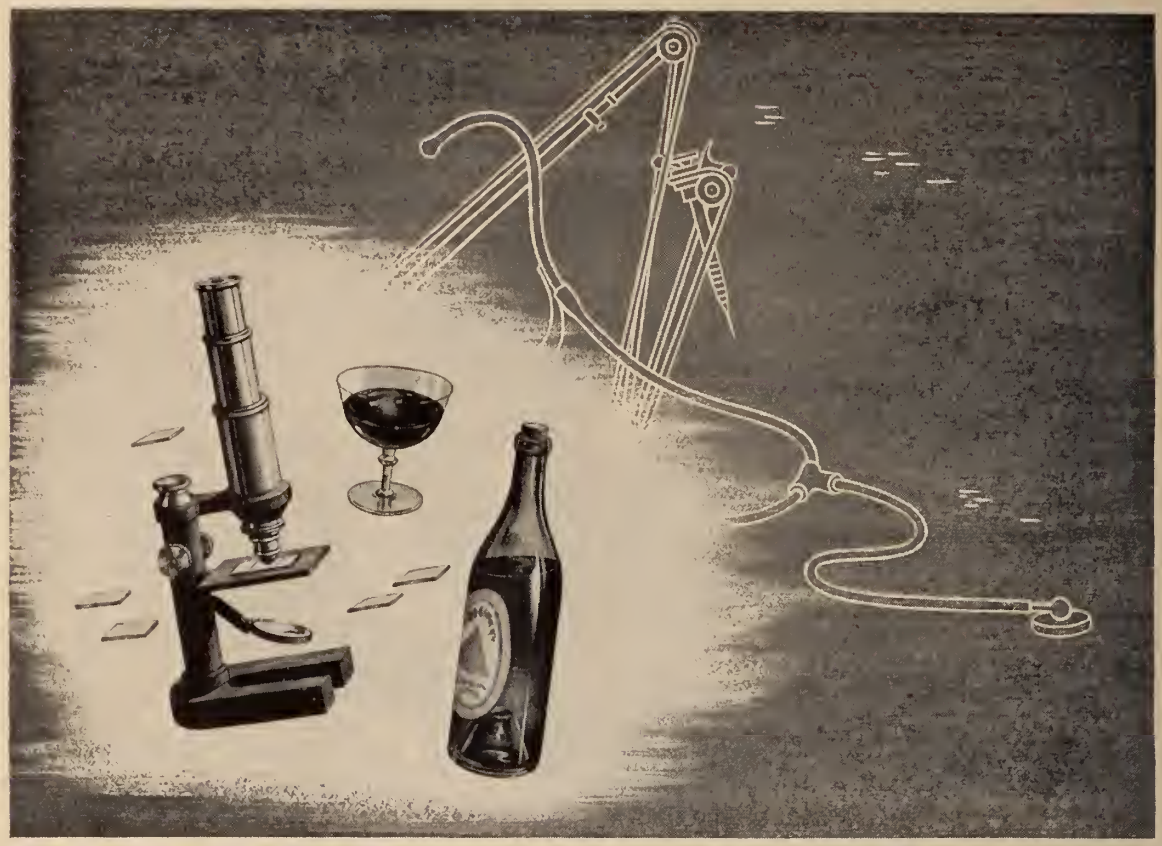

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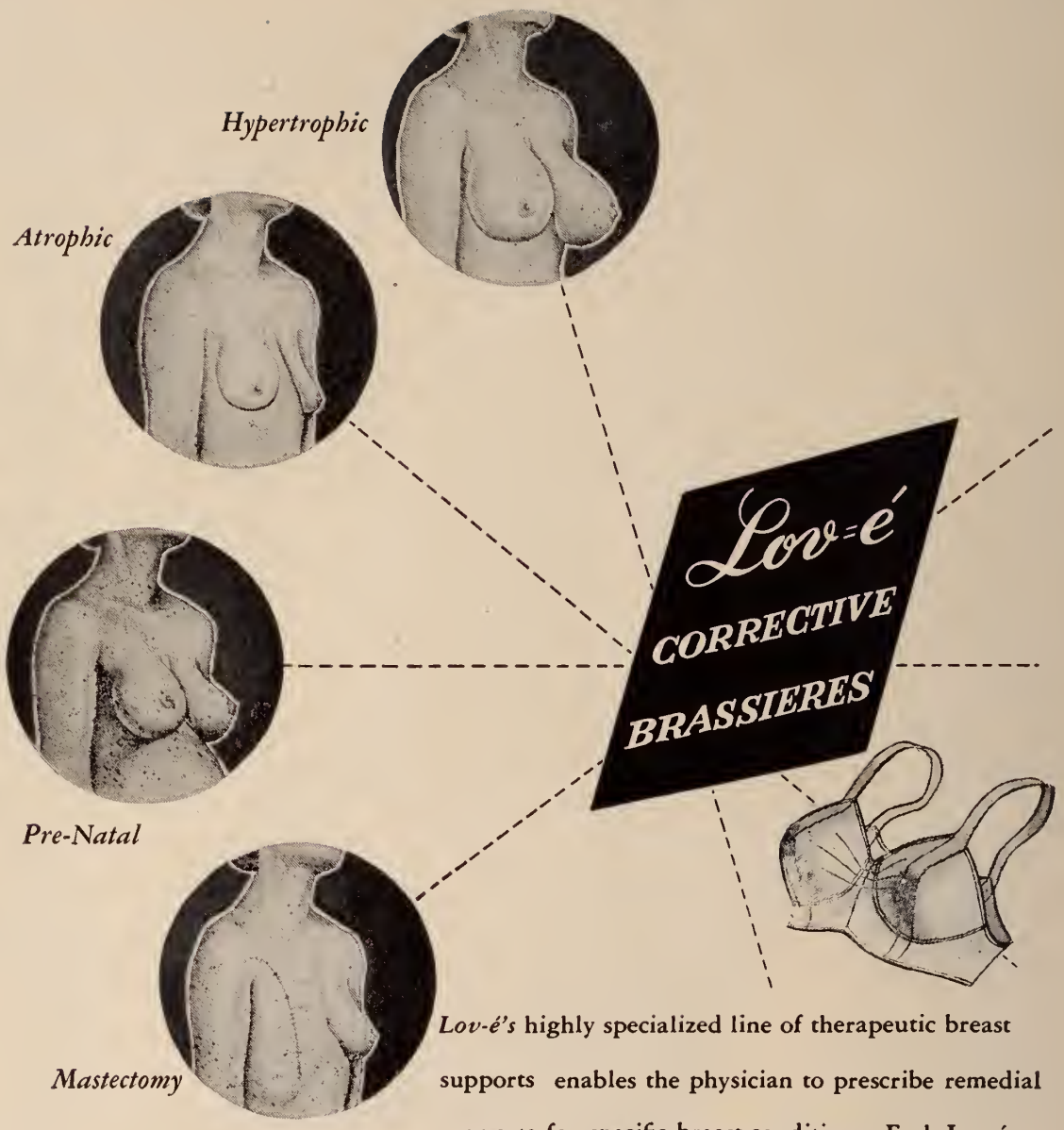

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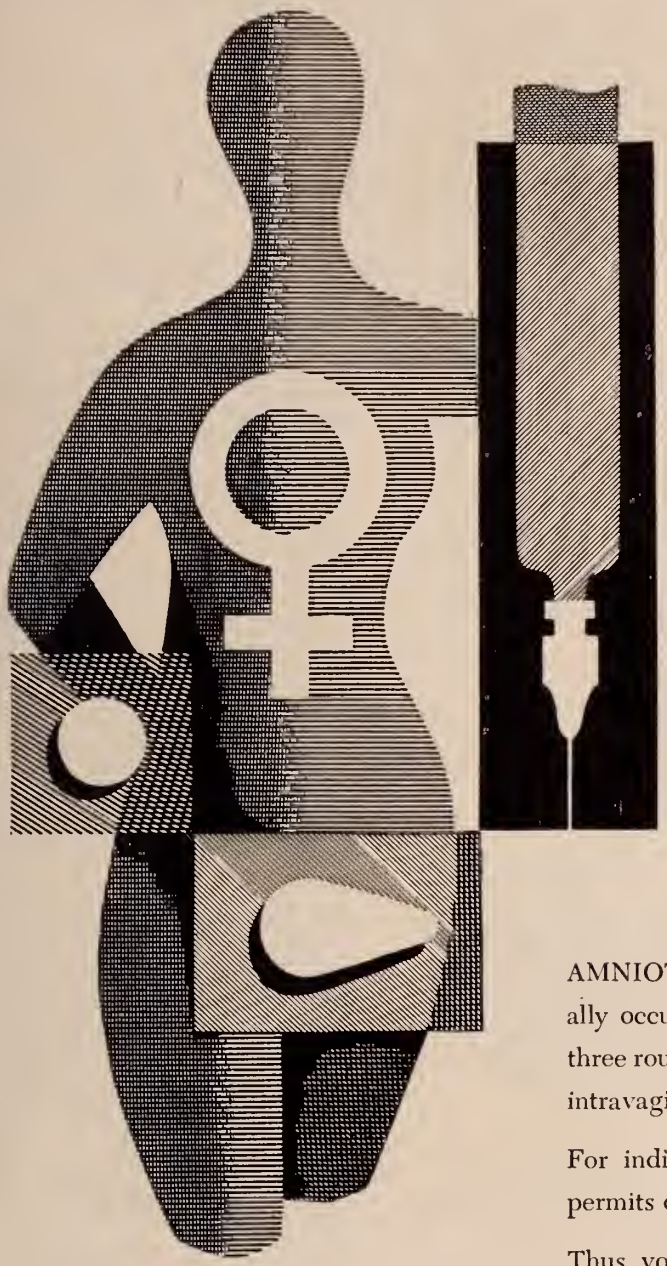

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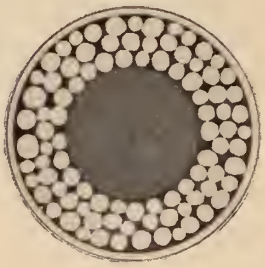

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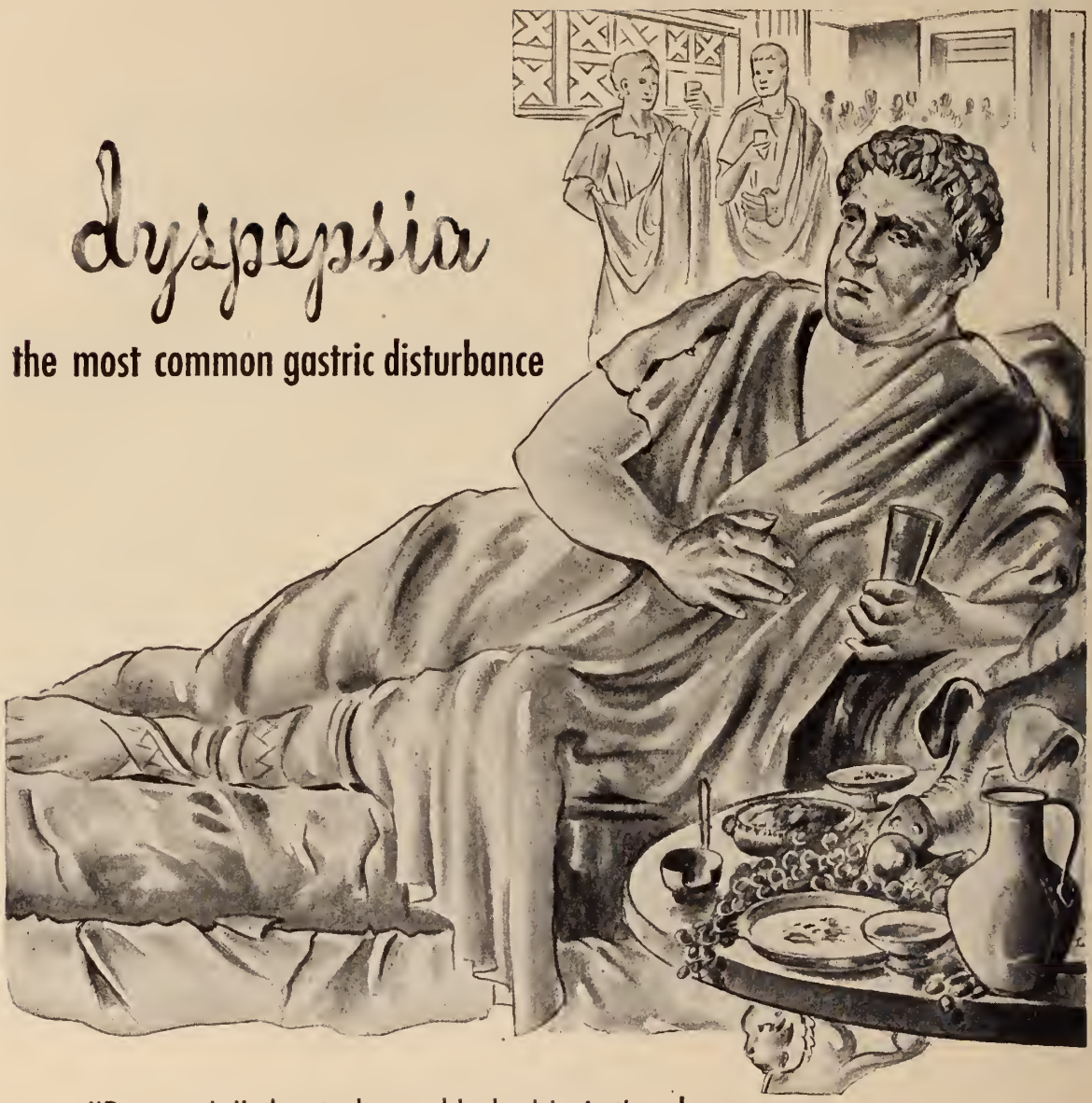

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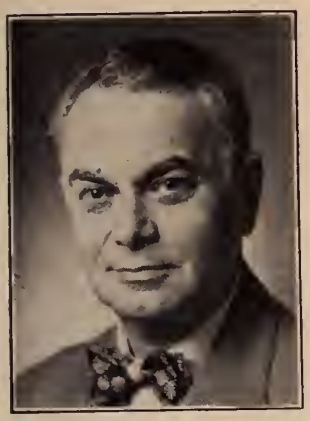
Treatment of Raynaud's Disease With Nitroglycerine

By MAX J. FOX, M. D., and CHARLES L. LESLIE, M. D.

Milwaukee



M. J. FOX

Doctor Fox, a diplomate of the American Board of Internal Medicine, is associate professor of internal medicine at Marquette University School of Medicine. He also serves as a preceptor for the University of Wisconsin Medical School and as medical director of South View Isolation Hospital.

IN 1862 Raynaud[1] described a syndrome in which the hands and fingers, on exposure to changes in temperature, progress through a series of color changes. Following exposure to cold they become white and soon assume a bluish discoloration. Thereupon after being exposed to heat they become fiery red and swollen and burn intensely.

Since that time, much investigative work concerning the etiology, pathology, and mechanisms of these phenomena has been carried on. Many controversial theories have been explored, and the syndrome has been extended to embrace many additional clinical features. Raynaud noted that some of his patients with these vascular changes also had a peculiar sclerosis of the skin. Several names have been attached to this dermatosclerosis, and some observers have made distinctions between various clinical varieties. O'Leary[2] described two forms: (1) acrosclerosis, involving only the hands, upper extremities, face, and neck; and (2) generalized scleroderma, affecting the entire body. He placed a better prognosis on the former. Goetz[3] believes that all of these phenomena and sclerotic processes are varied manifestations of the same pathologic process and doubts that any differentiation is justified. He presents a splendid paper covering 13 cases of "generalized systemic sclerosis." In these cases almost every organ and tissue in the body showed pathologic changes. In some of these cases the condition began as uncomplicated Raynaud's disease and progressed to the stage of a generalized systemic sclerosis.

Most observers agree that these conditions occur predominantly in the female in the third and fourth decades and are more common in persons of somewhat unstable nervous make-up.

Two schools of thought exist regarding the mechanism of Raynaud's phenomenon: (1) that a local pathologic condition exists in the minute vessels of the skin and fingers; and (2) that angiospasm of the minute vessels of the skin and fingers occurs because of abnormal stimuli through the sympathetic nervous system.

Mufson[4] concludes that there are both emotional and physical factors involved and that in certain individuals there is an exaggeration of vasoconstriction responses to these factors. In these individuals there is a continuous discharge of sympathetic stimuli causing partial vasoconstriction of these vessels producing anoxemia and the characteristic white color of the hands associated with numbness. When the stimulus for constriction has disappeared, there is a reactive hyperemia, causing increased blood flow and local hypertension. Because of the distended vessels, the skin assumes a fiery red color, and a burning sensation is noted by the patient. If there is a large amount of blood stagnated in the venules during complete vasoconstriction, lividity will be noted rather than paleness. When these episodes are repeated frequently, the ensuing anoxemia causes injury to the vessel endothelium, with the formation of a nonspecific endarteritis. This, in turn, favors thrombosis and irreversible local damage.

Hyndman and Wolkin[5] believe that "Raynaud's disease is caused primarily by an abnormality of the vascular system," but state that in individuals with this disease the skin arterioles may be abnormally sensitive to sympathetic stimulation. This is in contradistinction to Mufson's[4] point of view that the emotional factor is the primary abnormality.

Many investigators have attributed the local phenomenon to arterial spasm alone. Naide and Sayen[6] point out that venospasm also may occur and that the clinical variations may be explained by the type and amount of prevailing vessel spasm; predominant arterial spasm causes blanching with or without cyanosis, but without swelling; mixed arterial and venous spasm result in blanching, cyanosis, and swelling with absent or minimal blanching.

Therapy in Raynaud's disease has been generally disappointing. We have had the privilege of treating 2 patients with a new preparation. In both cases several clinicians had confirmed the diagnosis of Raynaud's disease, and in each case previous treatment had been unsuccessful.

CASE 1.—Mrs. S. R., aged 40, a housewife who has spent her life in New England and midwestern states, presented herself in the winter of 1943–1944

to a medical doctor because her hands became numb and "dead white" upon exposure to cold, the white color gradually becoming purple and, upon exposure to warmth, becoming fiery red, swollen, and burning. The swelling was a constant feature through the winter and was exaggerated upon exposure to cold. The tips of the fingers became tender to touch, and eventually an infected ulcer developed under the nail of the left index finger. During the summer of 1944 the ulcer healed and all of the symptoms were minimized.

With the advent of winter in 1944–1945, the symptoms again became marked and an ulcer developed under the nail of the right second finger. In the following summer the ulcer healed and symptoms again markedly diminished; but with the onset of cold weather in 1946, the pain, color changes, and swelling flared again and an ulcer developed under the nail of the right index finger. During the summer of 1947, this ulcer did not heal, and the patient noted the gradual formation of an area of black necrosis on the tip of the right index finger. At the beginning of the cold season in 1947, the condition became progressively worse.

Since the onset of her illness, the patient has been diagnosed on three occasions as having Raynaud's disease. In the fall of 1946 the Mayo Clinic made a diagnosis of Raynaud's disease.

The symptoms were progressing in severity each year, and the degree of relief experienced in the warm months was diminishing. During the course of the disease many therapeutic approaches have been attempted, including vitamins, the parenteral use of papaverine, and the parenteral use of alcohol. With the exception of the last, all were not beneficial. The alcohol injections gave fleeting relief, but not of such degree that continuance of this therapy was indicated.

In October 1947, the patient came under the medical care of the authors. A right unilateral stellate ganglion block had been done with 15 cc. of 1 per cent Novocaine previously. This caused Horner's syndrome, and the right hand became pink and warm. Because of the alleviation of symptoms noted with this block, the patient was referred to the Mayo Clinic for a possible sympathectomy. Dr. A. W. Adson suggested that surgical treatment be delayed and that the topical use of 2 per cent nitroglycerine in lanolin three times daily be tried. At the time this therapy was instituted, the physical examination was not remarkable except for moderate swelling of the hands, which were grayish white in color and cool to touch. The finger tips were tender, and a secondarily infected ulcer was present under the nail of the right index finger. There was also a black area of necrosis, 2 cm. in diameter, on the tip of the right index finger.

Since using the nitroglycerine preparation, the patient notes that her hands are now persistently pink in color rather than white. The amount of swelling of the fingers has markedly decreased. The ulcer on the tip of the right index finger has healed, and the gangrenous area on the same finger has decreased to approximately 2 mm. in diameter. The finger tip tenderness has decidedly decreased. The characteristic response to exposure to cold has lessened in severity.

CASE 2.—Miss A. S., a 30 year old unemployed white stenographer who has spent her life in Milwaukee, presented herself to a physician in the winter of 1943–1944 because of episodes of pain and color changes in her hands and fingers upon exposure to cold. The hands and fingers became numb and white after exposure, turned blue, and, after being warmed, became swollen, fiery red, and burned intensely. The feet were similarly affected but to a lesser degree.

During the summer of 1944 there was regression of the symptoms, but with the onset of cold weather the condition recurred. At this time the patient also noted that her skin was becoming darker over the entire body. The skin seemed to be "tight and drawn," assuming a glistening appearance, especially over the dorsal surface of the fingers.

From 1944 until 1947 all of the symptoms were progressive, and the previously experienced relief during the warm months grew less and less. The patient also noted that she was gradually losing the motion of her wrists and fingers.

During this time, the patient consulted several physicians. At the onset, she was told that she had a form of arthritis. Later investigators made a diagnosis of acrosclerosis with Raynaud's phenomenon. Many forms of treatment were tried, including the oral use of Benadryl, papaverine, and thyroid extract and the parenteral use of Prostigmine and tetraethyl ammonium chloride. The latter alone caused demonstrable fleeting benefit.

In June 1947, a thorough and comprehensive study was made at the Milwaukee County General Hospital, without uncovering any abnormal data and again establishing the diagnosis already made. Histidine mono-ascorbate therapy was instituted, but discontinued because of allergic side effects.

In December 1947, the patient sought medical care from the authors. Physical examination at that time

TABLE 1A.*—*Skin Temperatures (Centigrade) of Miss A. S. Before and After Treatment with Topical Application of 2 Per Cent Nitroglycerin in Lanolin. Room Temperature 28 C.*

	Before Treatment				After Topical Application of 2 per cent Nitroglycerine, December 29, 1947							
	May 19, 1947		Dec. 29, 1947		½ Hour		1 Hour		1½ Hours		2 Hours	
	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right
Thumb	----	----	32.0	32.7	33.6	33.4	33.2	33.4	35.2	35.0	32.0	30.6
Middle finger	32.3	32.6	32.4	32.7	33.2	33.4	32.8	32.8	35.0	35.0	31.4	30.2
Dorsum of hand	33.3	33.4	32.0	32.7	33.8	33.4	33.4	33.6	34.6	35.2	32.8	32.2
Mid-arm	33.0	33.4	32.6	33.2	34.2	33.6	33.4	33.6	33.8	35.2	32.9	33.6
Above elbow	33.3	34.2	32.0	33.2	34.2	33.8	33.8	33.6	35.0	35.8	33.4	33.6
Great toe	28.9	28.1	24.8	25.4	27.4	27.4	24.6	25.0	27.0	27.0	25.8	25.6
Instep	29.3	29.3	26.4	26.8	28.2	27.8	28.2	27.6	29.0	29.4	28.2	28.2
Anterior aspect of ankle	31.5	32.8	29.8	31.0	32.2	31.8	31.4	32.0	33.2	34.0	31.8	31.8
Below knee	31.5	32.5	31.4	30.4	33.2	31.8	32.0	32.0	34.0	33.2	31.2	32.4
Lower 1/3 of leg	33.6	34.2	32.0	32.0	33.2	33.6	34.6	32.8	34.8	35.6	32.8	33.4

*Through the courtesy of Ray Piaskoski, M. D., Milwaukee County General Hospital.

TABLE 1B.*—*Skin Temperatures (Centigrade) of Mrs. S. R. Before and After Treatment with Topical Application of 2 Per Cent Nitroglycerin in Lanolin. Room Temperature 28 C.*

	Before Treatment Dec. 29, 1947		After Topical Application of 2 per cent Nitroglycerine							
			½ Hour		1 Hour		1½ Hours		2 Hours	
	Left	Right	Left	Right	Left	Right	Left	Right	Left	Right
Thumb	27.2	28.4	27.8	28.6	28.2	29.6	30.0	31.6	27.8	29.0
Middle finger	27.2	27.8	27.2	28.0	27.6	28.4	29.8	35.8	28.0	29.4
Dorsum of hand	31.0	31.2	30.8	31.8	31.8	31.4	34.0	34.6	31.2	32.0
Mid-arm	33.0	33.2	32.0	32.6	32.6	33.0	34.6	31.4	32.4	33.4
Above elbow	34.0	33.6	33.2	33.6	34.0	33.6	35.4	31.6	33.6	33.8
Great toe	25.6	26.6	25.4	27.2	25.4	27.6	28.0	28.4	24.6	26.8
Instep	28.0	28.8	28.0	28.2	27.8	28.6	29.6	29.6	27.0	28.0
Anterior aspect of ankle	31.6	31.0	30.4	30.2	30.6	30.2	31.6	31.2	29.8	27.0
Below knee	31.6	32.4	31.0	31.2	31.4	31.4	33.4	34.0	31.8	31.2
Lower 1/3 of leg	32.4	32.4	31.8	32.0	32.0	32.0	33.4	33.0	31.6	31.4

*Through the courtesy of Ray Piaskoski, M. D., Milwaukee County General Hospital.

revealed a well developed, well nourished, white female with a diffuse increase in skin pigmentation. The skin had a tight, glistening appearance, most marked on the dorsal surface of the hands and fingers. The hands and fingers showed a contracture type of deformity with pronounced impairment in range of motion. The skin on the hands and fingers was grayish blue in color and cool to touch. Exposure to cold caused color changes typical of Raynaud's disease. Remaining physical findings were negative. Treatment with the topical application of 2 per cent nitroglycerine in lanolin three times daily was instituted.

Within ten minutes after the first application of the nitroglycerine, marked free perspiration was noted in the palms of both hands. It was of interest to hear the patient state that she had not observed perspiration of her hands for the last four years.

Since the beginning of the treatment the patient has noticed a slow improvement in the motion of her fingers so that she can bend her fingers to touch the palms of her hands with her finger tips. She has also been able to do the ironing and other domestic duties which she had previously been unable to do.

Discussion

Despite differences in opinion about Raynaud's disease, most investigators believe a local vasodilatation to be a desirable therapeutic effect. That this should be true is reasonable when one considers that local vasoconstriction is the direct cause of the symptoms and complications. If vasodilatation can be accomplished, some degree of amelioration of signs and symptoms can be expected, the degree of relief depending upon the amount of permanent local vascular damage.

Mufson[4] believes that therapy should include primarily the removal of any existing emotional factor and that secondary treatment should be aimed at local pathologic states, the type of secondary treatment depending upon the amount of involvement. In cases with minimal pathologic changes, protection from exposure will usually suffice. If local changes are occurring, more vigorous vasodilator therapy, aimed at increasing local circulation and stimulating collateral circulation, is deemed necessary. He adds, however, that the medical care of these patients is not satisfactory, since all known preparations for accomplishing local vasodilatation are inadequate due to their fleeting action. He further points out that sympathectomy is of value in some cases but that poor results do occur, probably because of the impossibility of completely disassociating the emotions from the vessel musculature.

It may be said that no consistent means of accomplishing local vasodilatation has been developed.

Mulinos[7] and his associates presented 5 cases in which the patients were treated with papaverine hydrochloride intravenously in doses of 60 to 120 mg. three times per week in conjunction with histamine iontophoreses. In their cases good results were achieved, and this was the experience of other investigators, such as Naide and Sayen,[6] who state: "vasodilators such as mecholyl bromide we have found to be of only occasional benefit."

It may be concluded that the medical management of Raynaud's disease has not been encouraging.

For some time, sympathectomy has been used to accomplish local vasodilatation in cases of Raynaud's disease. In some cases dramatic abatement of symptoms has been observed. However, in approximately 50 per cent of the cases, surgical treatment has been a bitter disappointment.

The conditions in both of the presented cases had been refractory to previous treatment. Miss A. S. had been told that therapeutic approaches had been exhausted. After using the nitroglycerine preparation three times daily for several days, the patient noted that her hands were pink and felt much warmer than previously. She felt that the response to cold was also less intense. However, after using the preparation three times daily for ten days, she noted that her hands began to itch and she observed several large red blotches on her hands. The veins on the dorsa of the hands were prominent and dis-

TABLE 2.*—*Oscillometric Readings Taken Before and One Hour After Topical Application of 2 Per Cent Nitroglycerin in Lanolin (Dec. 29, 1947)*

Anatomic Region	Miss A. S. (Blood Pressure 112/70)				Mrs. S. R. (Blood Pressure 90/50)				Normal
	Before		After 1 Hour Nitroglycerine		Before		After 1 Hour Nitroglycerine		
	Left	Right	Left	Right	Left	Right	Left	Right	
Foot	0.0	0.0	---	---	0.0	0.0	---	---	trace to 1
Above ankle	1.5	1.0	---	---	1.0	1.0	---	---	1— 5
Mid-leg	2.0	1.0	---	---	3.5	2.0	---	---	3— 8
Below knee	3.5	3.0	9.0	7.0	2.5	2.5	5.0	7.0	4—10
Lower 1/3 thigh	1.5	1.5	---	---	1.5	1.5	---	---	8—15
Hand	0.0	0.0	---	---	0.0	0.0	---	---	trace to 1
Above wrist	2.0	2.0	---	---	1.5	2.0	---	---	1— 3
Forearm	1.5	2.0	---	---	2.5	2.5	---	---	3—10
Mid-arm	2.0	2.5	---	---	3.0	3.5	---	---	5—12

*Through the courtesy of Ray Piaskoski, M. D., Milwaukee County General Hospital.

tended and the finger tips were tender. The drug was discontinued. At that time we felt that this was a congestion phenomenon, probably due to incompetent venous drainage. These symptoms disappeared in three days and the nitroglycerine was again started, but with only one application per day. To date there has been no repetition of this unfavorable reaction.

Mrs. S. R. was being considered for a sympathectomy at the time the nitroglycerine therapy was started. Decided objective and subjective improvement followed its use. The ulcer-gangrenous phenomena healed. The hands became pink and much warmer than previously. The swelling decreased markedly. The tenderness of the finger tips disappeared to such an extent that the patient was enabled to play the piano again for the first time in four years.

Skin temperatures during the use of the preparation were not remarkably increased (see table 1 *A* and *B*). However, oscillometric readings as shown in table 2 denote a definite and even marked increase. It is assumed that this increase in oscillometric readings indicates an increase in blood flow.

Both patients occasionally experienced a vasodilator type of headache with the nitroglycerine preparation, but this has not been of such nature as to warrant discontinuing therapy. Blood pressure changes during treatment with this drug have not been remarkable.

Foreign literature concerning the use of this preparation was not available to us because of the censorship during the war years. The use of this preparation does not appear in the American literature.

Although 2 cases certainly do not establish the efficacy of the preparation, we feel that the results were sufficiently encouraging to warrant their presentation, especially since the conditions in both cases had resisted prior therapeutic attempts.

Summary

1. Several theories regarding the mechanisms of Raynaud's disease are presented.

2. Two case histories are reported with the treatment and response of the patient.

3. Inadequacies of reported therapy for Raynaud's disease are noted.

4. Two per cent nitroglycerine in lanolin is presented as a topical therapeutic agent.

Conclusion

Two per cent nitroglycerine in lanolin applied topically is of value in the treatment of Raynaud's disease and deserves further investigation and clinical evaluation.

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Carcinoma of the Common Bile Duct

Report of a Case, With Discussion

By J. A. KILLINS, M. D.
Green Bay

J. A. KILLINS

A graduate of the University of Nebraska College of Medicine in 1937, Doctor Killins interned at the Charles T. Miller Hospital in St. Paul. Joining the Army Medical Corps in 1941, he was separated with the rank of lieutenant colonel in 1945. After receiving his M.S. degree in surgery from the University of Minnesota Medical School (Mayo Foundation), he joined the staff of Green Bay Clinic. He is certified by the American Board of Surgery.

"The carcinoma [of the common bile duct] may be readily recognizable as a thickening of the wall of the duct, but often it appears to be a simple stricture and its malignant nature is only recognized on microscopic examination."

—E. T. BELL

THE purpose of this paper is to present a case of carcinoma of the common bile duct and to comment upon the similarity of the clinical course to that of a benign biliary stricture.

The patient, a 68 year old white widow, was first seen at the Green Bay Clinic on Feb. 25, 1947. She complained of a deepening yellow color of the skin of about a month's duration, lack of appetite, with loss of 34 pounds in weight, and itching of the skin.

A pelvic tumor had been removed in 1925. A cholecystectomy had been performed in 1934. In October 1945 she had fallen, fracturing her right hip. She made a slow but uneventful recovery. Aside from these facts her past and family history were noncontributory.

On examination the patient was found to be an emaciated elderly woman. The skin and sclera were deeply jaundiced. Her blood pressure was 134/84; the heart and breath sounds were normal. Examination of the abdomen revealed the scars of previous operations but no palpable masses or areas of tenderness.

The hemoglobin content was 96 per cent, the red blood cell count was 4,540,000 per cubic millimeter, and the white blood cell count was 6,300 per cubic millimeter. Icterus index was 90. The urine was deeply bile stained and the stools clay colored.

After fifteen days' observation of the patient on a high carbohydrate diet, intravenous administration of glucose, and parenteral use of vitamin K, an abdominal exploration was decided upon. The preoperative diagnosis was carcinoma of the head of the pancreas, but, as Hunt[1] has stressed, the jaundiced patient should not be denied the possible benefits of surgical treatment simply on the clinical assumption that the condition is inoperable.

Upon exposure of the common duct, it was found to be about 2 cm. in diameter proximal to a small, sharply demarcated stricture. Distally it continued on into the head of the pancreas as a normal-sized duct (fig. 1).

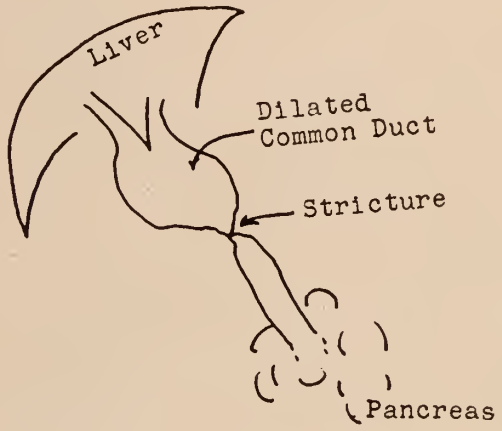

Fig. 1.

The stricture was excised and an end to end anastomosis performed over a T tube, the long limb of the T tube being brought through an incision distal to the anastomosis and through the abdominal wall by way of a stab wound to the right of the incision (fig. 2).

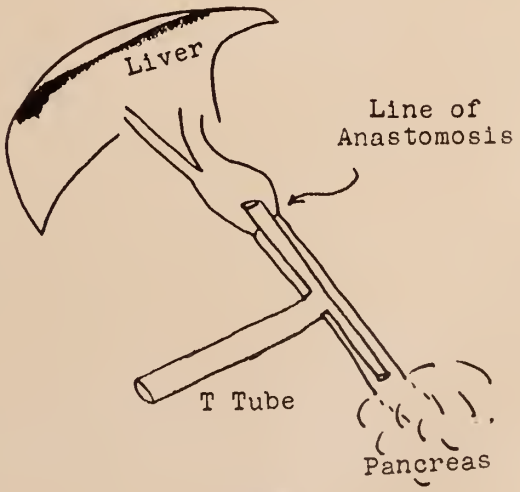

Fig. 2.

The convalescence was complicated by considerable drainage from the incision, causing excoriation of the nearby skin. The T tube was extruded from the wound on the thirtieth postoperative day. It had been our intention to leave the tube in place much longer. However, the patient passed brown stools on the fourth postoperative day and regularly there-

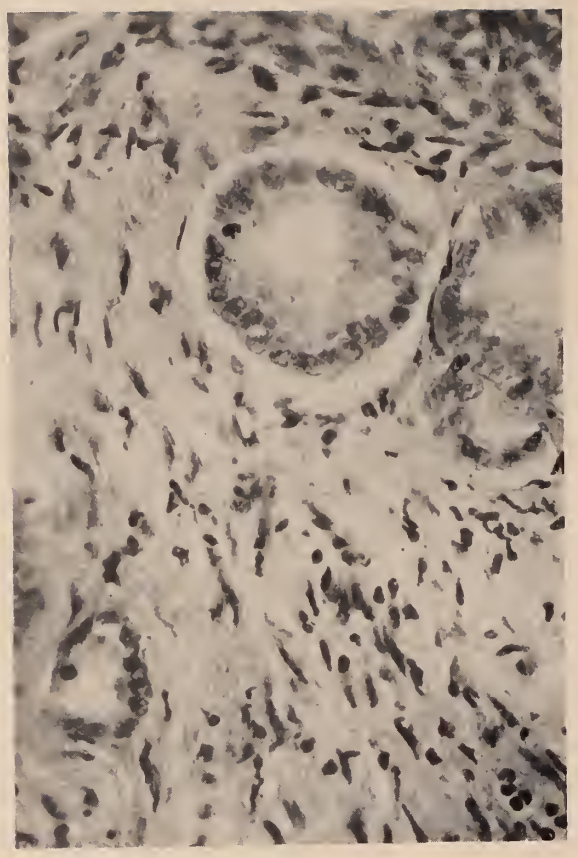

Fig. 3.—Carcinoma of the external biliary duct. x 400.

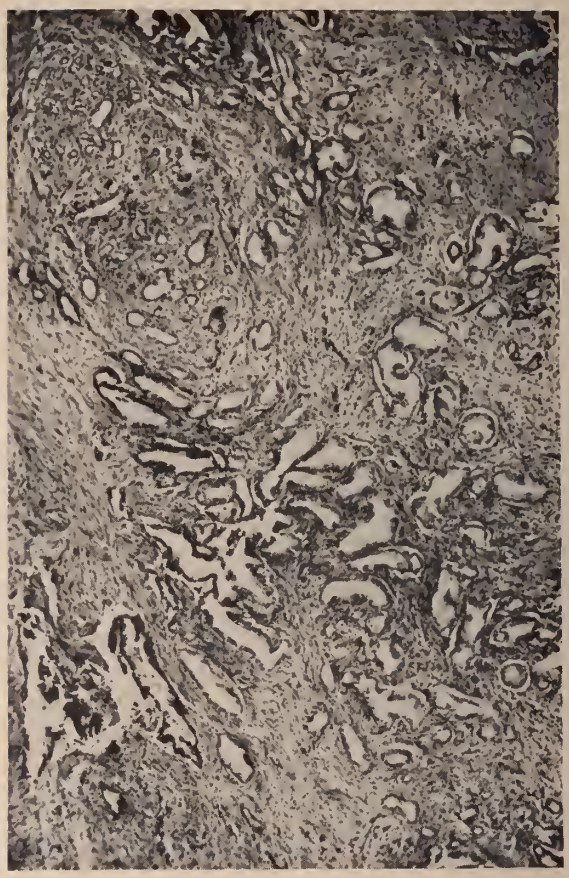

Fig. 4.—Carcinoma of the external biliary duct. x 50.

after. Three months after her operation she had an excellent appetite, had gained 28 pounds, and was free from jaundice.

Routine examination of the tissue removed from the common duct by Dr. H. H. Heitzman revealed a well differentiated carcinoma of the external biliary duct (figs. 3 and 4).

This was our first intimation that we were dealing with a malignant lesion. If the tissue had not been examined by a pathologist, the condition would have been considered a benign postoperative stricture of the common bile duct.

In August 1947, five months after the biliary anastomosis, the patient again became jaundiced. Again the urine was bile stained and the stools acholic. Her weight was down to 128 pounds from a postoperative high of 138. Her general condition was much better than at the time of her operation five months before.

On exploration Aug. 28, 1947 the proximal bile dust was found dilated as before. The distal portion could not be isolated in spite of diligent search. The surrounding tissues were friable and bled easily. There was no obvious evidence of cancer or any evidence of metastatic nodules in the liver.

A choledochoduodenostomy was performed, accurate mucosa to mucosa apposition being obtained over a rubber catheter and T tube (fig. 5).

Her convalescence was uneventful. She left the hospital on Sept. 10, 1947. Her jaundice faded once again and the stools were of normal color. On Oct. 1, 1947 her icterus index was 9.

At the time of writing, Dec. 23, 1947, she is well and active. Her appetite is good, and she is free from jaundice. However, her outlook is only fair. She may become jaundiced again from a mechanical obstruction before she succumbs to any recurrence of her carcinoma.

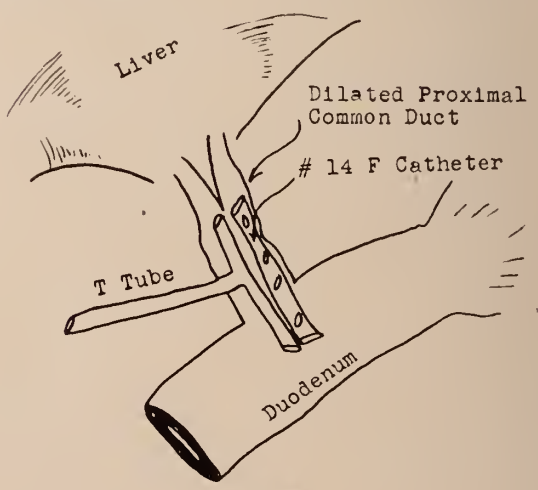

Fig. 5.

The history of painless jaundice following a cholecystectomy several years before with temporary relief following various plastic procedures on the external biliary tract almost exactly parallels the

dreary history of individuals whose biliary ducts have been accidently injured at operation.

It is reasonable to surmise that other patients believed to have benign common duct strictures are in reality suffering from carcinoma of the common duct. Unrecognized cancer may be a factor in the generally poor results of reconstructive surgical treatment on the biliary tract. The value of tissue examination by a competent pathologist is obvious.

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Focal Points in Child Development*

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M. J. E. SENN

Doctor Senn, a native of Milwaukee, is Sterling professor of pediatrics and psychiatry at Yale University School of Medicine, New Haven, Conn., and directs the Child Study Center at that institution. Following his graduation from the University of Wisconsin Medical School in 1927, he practiced in Milwaukee for a short time. Doctor Senn is also attending pediatrician at New York Hospital, New York.

ONE of the present day trends in medical education and research in our country is a greater consideration of growth and development of the human organism. It is natural that pediatrics leads the way in this advance of modern medicine inasmuch as it deals with a segment of humanity which is ever changing in growth and whose stages of physical development are seen in magnified overtness. Students of growth and development have reached certain conclusions about these processes, and one of the inferences of these workers is taken as the topic of this paper, namely, that there are *focal points in child development.*

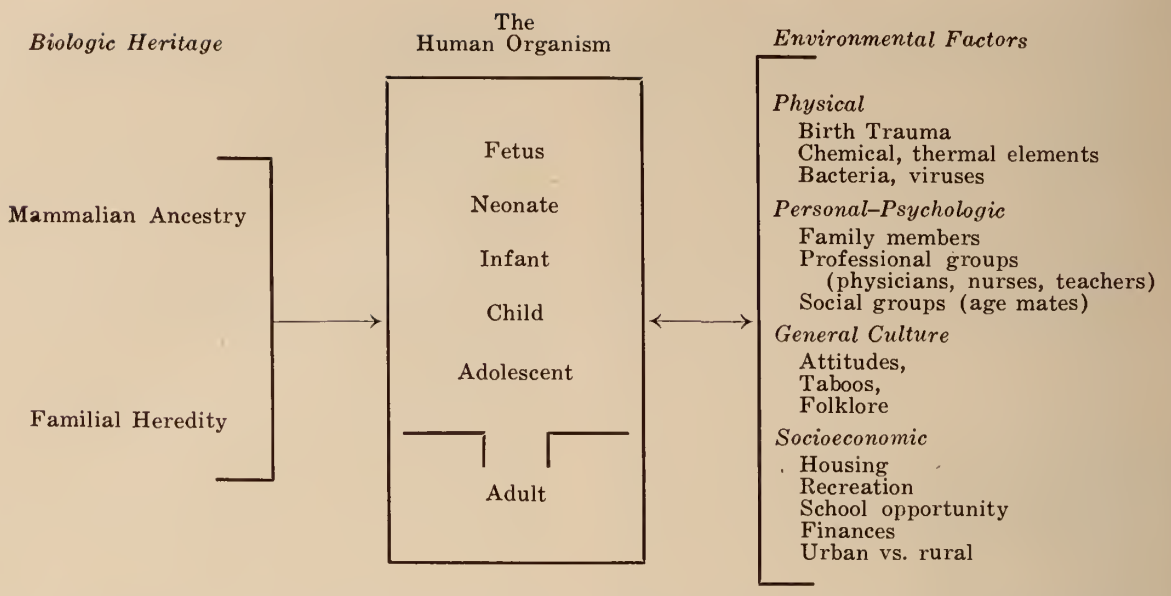
On examination and appraisal of studies of developing children, one becomes aware of the fact that research in this area centered for many years first on the biologic elements, then on the intellectual, and only recently on the psychologic aspects. Today, studies of this kind are tending to be comprehensive and include not only all the areas mentioned, but also the social components as well. Then, too, focus on the child has widened to include the milieu in which he is reared—the environment where he lives, plays, and goes to school. Further, the forces which act on the child, and to which he reacts, are evaluated.

*Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

Child Development Schematized

Viewed diagrammatically, one may vision child development as follows: the child, a biologic organism, is the product of, first, his mammalian ancestry and his individual familial heredity and, second, of an interaction between himself and various forces in his environment. These elements for the most part consist of physical, personal-psychologic, general cultural, and socioeconomic components. Each of these forces has different representative constituents. For example, the physical factors comprise such diverse influences as bacteria and viruses, thermal (heat and cold), and chemical (sun, food, etc.) elements, physical violence, and birth trauma; the personal-psychologic forces contain influences of family members (parents, siblings, grandparents), of playmates, teachers, physicians, and nurses who take care of the child-patient from his prenatal existence onward; and the general cultural pattern consists of the current attitudes in the community toward child care and child rearing, examples being the beliefs and feelings about infant feeding, infant behavior, and so-called "problem behavior" of the thumbsucking variety, and including taboos, folklore, and misinformation which make up part of the mores of the period. This concept of growth may be schematized as follows:

The product of the interaction between the individual, the organism, and the forces enumerated will depend upon such factors as constitutional resistance or susceptibility, amount and combination of forces, and the times of impact. The response of the fetus to certain physical states, for example, anoxia and maternal diet deficiency, varies during its intrauterine existence, the greatest vulnerability being in the first four months. Then, too, the combination of such influences as death of a parent and financial insecurity may have a greater adverse effect than loss of money alone. Again, a loss of parent is more of a psychologic trauma at certain times of a child's emotional development than at another. The mode of response of the individual will also depend on the phase of the human growth pattern that he is in when acted upon by one or more forces. For example, the newborn infant reacts to deprivation of food with crying, fingersucking, sleepless-



ness, and motor restlessness; his response is often a total body reaction; he puts his whole being into his demands to be fed; he reacts in a primitive manner. In contrast, the healthy child at the age of 4 years usually responds differently, first *asking* for food, then *demanding* it or trying to obtain it for himself, and then, if unsuccessful, resorting finally to the infantile response of crying, shrieking, and motor restlessness which would be labelled "tantrum" and considered in our culture as a bad or unwholesome character trait, and one which too often is handled by parents with punishment instead of with a more physiologic response in this instance, of offering food. The genesis of many of our so-called behavior problems is through such a mechanism; the child making a bid for a basic physiologic need, his manner of expressing his need being unacceptable in terms of adult standards, the mores of our time demanding discipline and control lest "spoiling" follow, with the result that the child is punished instead of being treated with understanding. His reaction sets up a chain of misbehavior, and a conflict ensues between child and adult which may, for a long period, even permanently, affect the development of the child and prevent the establishing of the joyful satisfaction which might come to the adult in child-rearing through participation in the growth processes of the child.

Research workers appraising human g r o w t h through long term longitudinal studies of living children have found that each human being follows a general growth pattern, yet at the same time demonstrates his own particular variation thereof. In spite of the individual differences, one may with surprising accuracy predict future development because of the constancy with which each person adheres to his own basic pattern. It is apparent that such prediction on a chronologic basis alone is usually much less accurate. For example, the foretelling of the exact age of walking, teething, or talking cannot be done. The sequences of phases of dentition, of motor development, and of behavior, however, may be prophesied for healthy children who have been under longitudinal observation for at least several months. Stating this differently, it may be said that the rhythm of development is more predictable than the rate.

Practical Application

The physician in general practice and in pediatrics may well ask what are the practical applications of this newer knowledge of human growth in terms of his medical management of the infant and child. What are the important focal points in child development that the medical and allied professions need be aware of and consider in child care both in sickness and in health?

In considering the developmental epochs in the life of the individual, one begins with conception, but about the physical and psychologic structure of this the physician can do little. Turning to the period of gestation, evidence is now abundant from both animal experimentation and human clinical records that nutritional deficiencies (particularly vitamins A, B, and D), chemical lacks (especially of iodine), and physical disease of the mother (notably german measles and toxoplasmosis) during the first four months of pregnancy predispose to malformations of the offspring. It is further recognized that the whole pregnancy is fraught with potential psychologic trauma or, conversely, with psychologic beneficence, depending on the maternal feelings and attitudes. These emotions do not have the cause-effect relationship of the maternal impression and fetal "marking" variety handed down in folklore, but rather a more subtle and intangible influence, yet one so powerful that one is tempted to devote a major portion of this paper to its discussion.

Psychologic Importance of Prenatal Period

At the New York Hospital in the past few years it has been customary to have pediatricians in training spend a portion of their time in the prenatal clinic of the obstetric department in order to learn from pregnant women what their questions and attitudes are regarding pregnancy, childbirth, and child care. From an analysis of the clinical records obtained this way, it is readily seen that the average pregnant woman has mixed emotions and attitudes about these events. There is often misinformation, apprehension, rational fear, and irrational anxiety. Multiparity is not distinguished from primiparity in this regard. Neither is professional experience insurance against concern and worry. The woman trained in medicine and nursing loses her objectivity when she becomes a patient, and in this is like a prospective father with abundant professional experience in medicine who yet may have greater concern about pathology in spite of (or because of) his medical background. What should concern the obstetrician and pediatrician is that pregnancy is an emotional as well as a physical experience in every instance. Of the greatest importance is the fact that the attending physician when aware of this is in a position to help the prospective parents as no one else can through listening, answering questions, reassuring, and guiding. Such medical treatment constitutes psychotherapy of the most potent variety; this is mental hygiene incorporated naturally into medicine as it should be. Our experience has been that prenatal guidance is good preparation for neonatal and infant care. For example, infant feeding should be discussed before the birth of the baby, when the mother raises questions about it. In this way, many problems of feeding may be prevented. Certainly breast feeding can be more easily carried out when the technics involved are discussed prenatally and when some of the problems are anticipated. This is all in line with the trend toward more breast feeding, and toward other child care practices, such as the "rooming-in" arrangement of the newborn, whereby the baby is brought to the mother for longer and more frequent physical contacts in the neonatal period in the hospital through having the baby share a room with the mother and through a breast-feeding arrangement which permits the child to eat whenever his hunger demands it. The experiments in these technics at the Mayo Clinic and at Yale University School of Medicine will be followed with interest, and, although in the future they may not be applicable in their entirety to medical practice elsewhere, the aims of the experiments are basic. Modern psychiatry emphasizes an old truth which many religions have taught for ages, namely, that the cornerstone of personality development, or of character if you will, is in the parent-child relationship, particularly the mother-child relationship in the first few years of life. Modern child care teaches that the practices of feeding in infancy have great significance in setting up good or poor relationships, that the giving of food to and infant provides not only calories but also emotional pleasure and satisfaction, thus permitting the establishment of a good bond of affection early in life between mother and child which should help carry each through the periods of trial and tribulation which appear in all child rearing.

Psychologic Development in Infancy

It is evident that the natal, neonatal, and infancy periods, like the prenatal period, are of the first magnitude as focal points in both physical and mental development. Birth requires great readjustment and the birth process may be a traumatic one. The infant's experiences immediately after birth also represent a change from his former way of living. The young infant is dependent and self-centered in his instinctive search for things that supply his basic needs. During this period the mouth is the organ used chiefly in relating the infant to the outside world, and the mouth is used for pleasure, to express feelings such as aggression and anger, and for exploration. It is now accepted that thumbsucking, biting, and putting things into the mouth are normal activities at this age. In fact, if the child after 6 months of age should not do these things, does not enjoy his food or show interest in things about him, one must suspect physical or psychologic pathology. As the infant grows, particularly as he approaches his first birthday and as he goes into the second year of life, he relates himself still more to objects outside himself, to persons other than himself and his mother. This phase is characterized in our culture by a gradual physical and psychologic weaning. It is a period of stress and strain because the infant is learning many new abilities, particularly in motor performance and talking, and because he is being trained in new technics such as self-feeding and toilet training, about which he has mixed feelings. During this period, emotional development centers around the physical experiences of habit training, and the infant's impressions and fantasies of the outside world are related to eating and to bowel and bladder evacuations and to the role of the adults, especially the mother, who participates in the experiences. At this time, the infant is interested in his excreta, and evacuation satisfies biologic and psychologic needs. There is evidence that toilet training is accomplished most satisfactorily and most physiologically if not begun too early or coercively. Children resent or resist early and rigorous training, resorting to sustained or periodic wetting and soiling or episodic holding back of feces and urine, and to fecal smearing, for as long as several years if training is started before they are able to sit unsupported, before they understand what it expected of them, and when they misinterpret the training as punishment or parental displeasure or disapproval. Clinically one may also see such regression in children who are institu-

tionalized or reared in other places where they are treated in a routine, regimented, and impersonal manner. Patients with mucous colitis on a psychosomatic basis also constitute a clinical group having early life histories of premature and forced toilet training. Another psychosomatic product of coercive toilet training is the constipated person, who shows also a compulsiveness about body cleanliness.

Psychologic Development in Preschool Period

In the preschool period of from 3 years to 5 years, the child is more keenly aware of himself as a person who is different from others. There is further attempt to emancipate himself from his parents, especially the parents of his own sex, and this struggle is akin to the drive seen in adolescents. The child moves ahead eagerly in gestures of independence, yet holds back in fear as if in danger of losing parents. The preschool child is able to verbalize these fears and talks about the possibility of losing his parents and he resists separation from them, particularly at night; he talks of death, sleeps poorly, and has nightmares. As he grows older he gives up many of these fears, or at least he talks less about them and sublimates through school activities. As a school child he finds gratification in the development of talents and special aptitudes; he develops hobbies and outside friendships with groups of age mates. The period of school age is usually less hazardous in terms of physical illness and, except for psychologic problems relating to the school situation and to learning, as a rule it contains fewer difficulties than the preceding phases of development or the next episode of puberty and adolescence. These last focal points may be mentioned only briefly at this time.

Psychologic Development in Puberty and Adolescence

Puberty is attended by spurts of growth, increased and fluctuant metabolism, and changes in blood chemistry, particularly in calcium and nitrogen balances and hormone contents. It is no wonder that the physical organism is easily undermined and becomes prey to tuberculosis, nutritional deficiencies, anemia, and endocrine disturbances. As a corollary to physical change, psychologic imbalance develops, runs concomitantly, and persists for several years after the physical changes seem to have become stabilized. Adolescence, which is the psychologic counterpart of puberty extends well past the twentieth birthday; the early emotional instability of this period is accompanied by greater identification with adults, first with parents and then with others outside the family circle, and with greater stabilization of mood and instinctual cravings comes the strengthening of heterosexual relationships which mark psychologic maturity. Adolescence exemplifies the fact that growth itself, although normal and spontaneous, may be attended by anxiety in the average person when it is accelerated in rate as in puberty. Many of the somatic complaints seen in this age period are the result of "normal" anxiety incident to this group. The adolescent whose body changes so drastically is filled with misgivings about his health and each discomfort may be mistakenly interpreted as disease. Physician and nurse more than parents are able to help such adolescents by correcting misconceptions, by listening sympathetically, and by reassuring. Contrariwise, parents and professional persons alike may increase fears by overemphasizing disease and ill health, by disregarding natural differences of persons, through fostering the notion that there is uniformity of body build and physical prowess of the so-called "normal" or by demanding physical and psychologic aptitudes which for a particular person are unphysiologic.

An attempt has been made in this paper to present development as a dynamic process, depicting the child as a living, changing, and growing biologic organism, developing and maturing through the interaction with a multidimensional environment made out of family, physical space of the natural world, and organized society with its distinct cultural pattern. The adult develops traits which mark him as the individual he is because of the pattern of his early life experiences. The physician acts as an important force in the unfolding of the human growth process. He does this through his capacity as a scientifically trained doctor who ministers to his patients from the time of conception, doing it best when he combines science with humanity and when, like the principal character in Anthony Trollope's "Doctor Thorne," he believes that the principal duty which one owes a child is to make him happy.

AMERICAN UROLOGICAL ASSOCIATION OFFERS $1,000 FOR ESSAYS

The American Urological Association is offering an annual award of $1,000 (first prize, $500; second prize, $300; and third prize, $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been in specific practice for not more than five years and to residents in recognized hospitals.

Further information may be obtained from Dr. Thomas D. Moore, Secretary, American Urological Association, 899 Madison Avenue, Memphis 3, Tennessee. Essays must be in his hands before Feb. 15, 1949.

Early Schizophrenia Complicated by Rheumatic Fever

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HENRY VEIT

Doctor Veit received his medical degree from Marquette University School of Medicine in 1943. After an internship at the Milwaukee Hospital, he spent thirty months in military service, assigned in neuropsychiatry. After psychiatric specialty training at the Columbia Neurologic and Psychiatric Institute and the Colorado Psychopathic Hospital, he is now completing his residency training at the Milwaukee County Hospital for Mental Diseases.

THAT psychiatry is not the study and treatment of mental diseases alone is exemplified by this study of a case. Here the rheumatic fever and the schizophrenic reaction are associated, but the interaction, if any, requires the reader's personal evaluation. Such inter-relationships have been described by Leys,[1] Bruetsch,[2] and Dublin,[3] who show the complexities of the problem. Hence, at all times it is necessary for the doctor to consider the "whole picture"—all the physical and psychologic factors presented by any one patient.

Study of a Case

Complaint by grandmother: "Tantrums. He turns white, 'crashes,' and threatens to kill."

Main Features of the Present Illness.—The informant related that the patient, J. D. W., had had temper tantrums all his life. His rage was uncontrollable and he broke things, after which he quieted down. The patient had lived with grandmother since Dec. 31, 1943. Earlier he had been with his father. J.D.W. had had four attacks of rheumatic fever with residual cardiac involvement. In July 1943, the father took J.D. south with him because of health and financial considerations. However, J.D.'s pyromanic tendencies necessitated frequent moves, and finally the father sent him to live with the grandmother.

At his grandmother's home, the patient had temper tantrums from Jan. 1 to 5, 1944, and care at a detention home followed. While there, he spent hours at a time in the "mat room," crying, screaming, and banging on the doors. Mental illness was suspected; hence transfer to the Colorado Psychopathic Hospital occurred Jan 12, 1944.

Personal History Essentials.—The patient was born Feb. 4, 1932, at a hospital in Denver, Colo. Birth and early development were entirely normal. Scarlet fever, without sequela, occurred at the age of 5. He had had rheumatic fever episodes in 1940, 1941, 1942, and 1943. He had had heart trouble since the first attack. School attendance had been regular until June 1943, and the fifth grade level was attained. Drawing ability was noted early in life. He had always been quarrelsome and had never been able to get along with other children.

Family Background.—This was negative for nervous and mental disease. The patient was an unwanted child. The patient's mother died of a brain abscess when he was 4. The patient was raised by a schizoid father and domineering grandmother. One sister, aged 13, living with the grandmother, appeared to be well adjusted.

Mental Status.—At admission, the patient was seen to be a small, fairly neat, clean, white male of 11 years of age. He was cooperative, initially shy, but soon was able to talk spontaneously. Answers to questions were relevant and coherent, with logical goal ideation. Psychomotor activity was somewhat retarded. There were some evasive trends. Paranoid ideas were directed toward his grandmother. Orientation was good. He correctly presented four digits forward and in reverse. Calculation was below the fifth grade level achieved. General information, judgment, and insight were poor.

During the hospitalization, silly behavior and talk, preoccupation, disorientation, and delusional and hallucinatory activity occurred. He said, "Someone is throwing things at me. That is a pretty red ribbon you are wearing." He talked about rats in his neck, Germans and Japanese attacking him, and the black panther in his room. On one occasion he crawled about on all fours and "yelped like a dog." Predominant were delusions related to death and represented by bizarre drawings of skulls, the devil, and the "Grim Reaper." (The latter is an appropriate title for the attached picture.)

Physical Examination Summary.—This rather underdeveloped white boy appeared about three years younger than his stated age of 11. The heart was enlarged to the left by percussion, and there was a loud systolic murmur audible over the entire precordium. The clinical impression of rheumatic heart disease with mitral stenosis and aortic insufficiency was formulated. The residual examination showed findings entirely within physiologic norms.

Significant Laboratory Reports.—Roentgen examination of the chest on May 4, 1944, showed very marked enlargement of the heart bilaterally (transverse diameter 18 cm., compared with 22 cm. thoracic width). On Oct. 1, 1945, there was very marked enlargement of the heart bilaterally (transverse diameter 18 cm., compared with 26 cm. thoracic width). There were extensive congestive changes in both lower lobes. No definite evidence of pleural effusion was present.

A urinalysis report on Jan. 13, 1944, showed an acid reaction; a specific gravity of 1.025; 1 plus cell; 1 squamous epithelial cell; and amorphous sedimentation rates 4. On Nov. 7, 1945, there was an acid reaction; a specific gravity of 1.012; albumin 4 plus; fine granular casts, 1 plus; 1 pus cell; 1 squamous epithelial cell; 2 to 3 red cells; 4 bacteria; amorphous sedimentation 2; and mucus occlusion.

Blood examinations on Jan. 13, 1944, showed a hemoglobin content of 12.2 per cent; 4,820,000 erythrocytes; 15,500 leukocytes; polymorphonuclears 62; lymphocytes 33; and endothelial cells 5. On July 12, 1944, an examination showed a hemoglobin content

of 12.2 per cent; 5,680,000 erythrocytes; 24,400 leukocytes; polymorphonuclears 54; lymphocytes 27; endothelial cells 12; and eosinophils 7. There was marked achromia.

An electrocardiographic report on Aug. 15, 1944 showed left axis deviation (slight). Large P waves indicated auricular pathology. There was no definite diagnostic pattern present.

Significance of the Photographed Drawing Entitled "The Grim Reaper."—This drawing was completed at a time when the patient's speech and behavior indicated fear associated with death anticipation. He expressed many bizarre ideas about death and even actually stated that he had been told he would not live long. Delusional and hallucinatory

Drawing by patient at 11 years, entitled "The Grim Reaper."

activity regarding death seemed to revolve around the bizarre figure illustrated. At intervals, extreme apprehension appeared when the patient felt that the "Grim Reaper" was calling him. Thus, the patient expressed his prevailing emotional disturbance in this concrete form.

Clinical Course.—During the first two weeks after admission the patient manifested a sullen, uncooperative attitude, delusions, and hallucinations and was intermittently destructive and irritable. He was started on insulin shock therapy Jan. 28, 1944, but after six doses, insulin was discontinued because of persistent leukocytosis and emesis. Seclusion now became necessary, as he was constantly destructive and exhibitionistic. Insulin, reinitiated March 16, 1944, was complicated by a prolonged reaction on April 8, with a temperature of 104 to 106 F., clinical signs of subacute bacterial endocarditis, and exacerbated hallucinatory activity. On April 14, the medical consultant diagnosed a possible thrombosis of the central retinal artery or a cavernous sinus thrombosis on the right. By April 20 gradual recovery began to occur.

On May 3 the patient was discharged to the father against advice. He was returned in three hours, as he was uncooperative, incoherent, and hallucinatory. Tube feeding was required for several days. At this time, he began to draw many bizarre-colored pictures and "soaped up" his face and the walls of seclusion room with death illustrations. He was tried by a commission in lunacy on April 23, 1944, adjudged, and committed, but was refused by the Colorado State Hospital because of his age.

Insulin again was utilized on June 19, 1944 but was discontinued completely on Nov. 11, 1944, after one hundred and thirty-nine days of treatment and five deep comas. During this period, digitalization was employed briefly for cardiac failure. In general, his physical and mental health indicated progressive deterioration. Twelve grand mal seizures obtained during electroshock therapy from Nov. 20, 1944 to Feb. 29, 1945, were given for constant assaultive destructive behavior.

From March 1945 until his demise, Nov. 7, 1945, his behavior was marked by impulsivity, destructiveness, and excreta carelessness. Two acute febrile episodes (rheumatic fever episodes) of three weeks each marred the constancy of this behavior. After Oct. 1, 1945 the patient became completely bed-fast, with signs of cardiac decompensation. This was demonstrated by generalized edema, dyspnea, orthopnea, liver tenderness, increased enlargement of the heart with qualitative murmur changes, and a low grade fever. Paracentesis was necessary several times for ascites. Autopsy permission was not granted upon the patient's death Nov. 7, 1945.

Etiologic and Psychopathologic Factors

A dynamic formulation of the etiologic and psychopathologic factors indicates the basic substratum for this mental illness. When the patient was 4 years old, psychologic maternal deprivation caused severe, repressed hostility and guilt feelings. As an unwanted child, aggravated "death wishes" toward the mother were most likely, even with the admixture of some degree of affection. Continued rejection by the schizoid father and the domineering strict maternal grandmother resulted in rejection of them, and eventually all contacts (withdrawal from reality) with an overflow of hostility and resentment in acts of social aggression. Periodic invalidism since the age of 7 as the result of recurrent rheumatic fever episodes led to unrestricted liberties, with consequent lack of standard social behavior. The role of possible toxic factors associated with rheumatic fever and subacute bacterial endocarditis cannot be evaluated.

Discussion

Despert[4, 5] states that the most likely combination of deviations which have significance from the point of view of later development of schizophrenia includes early dissociative phenomena, language dissociation, lack or inadequacy of socioaffective rapport, compulsive behavior together with anxiety, and severe and persistent temper tantrums.

Childhood schizophrenia, according to Bender,[6] does not usually occur as a narrowing of brain function but as a dramatic emergence of special abilities in artistic fields, in language experimentation, and in philosophic preoccupation with problems of social relationships, time, and space. In this patient, the deviate artistic ability is self-evident in the appended picture.

In the characterization and discrimination of juvenile schizophrenia, Erich Benjamin, Leo Kanner, Charles Bradley, and J. Louise Despert have done the most. Kanner[7] gives the following series of symptoms for juvenile schizophrenia: withdrawal from the environmental realities, general emotional blunting, mood and thought discrepancy, delusions, ideas of reference, hallucinations, "queer" performances, and incoherent and irrelevant verbal expressions. The clinical course of J.D. is replete with many of these symptoms. The clinical diagnosis of schizophrenia was corroborated by the Rorshach psychologic test, which featured a severe lack of personality integration. Harms[8] and other observers emphasize as a difference between juvenile and adult schizophrenia, the juvenile's frequent ability to perform normally again for a short period of time.

Therapy recommended by Cottington[9] includes primarily socialization, shock therapy with erythroidine-Metrazol, and psychotherapy. The basis for the socialization program is the tolerant attitudes of all adults toward the bizarre behavior of the child. The various methods utilized in psychotherapy were play therapy, art, dance, free discussion, and psychoanalysis. In J.D., insulin therapy was utilized without benefit; the socialization plan was carried out, and art and free discussion were the principle tools in psychotherapy.

Potter and Klein,[10] and Lurie, Tietz, and Hertzman[11] report almost uniformly bad prognosis from study of their series of cases. Bradley[12] covers the literature on schizophrenia of children and can present no universally successful treatment. Successful psychoanalytic therapy in 1 case was reported by Melanie Klein[13] in her paper on symbol-formation. The complication of rheumatic heart disease in J.D. eventually resulted in death after a hospitalization of almost two years.

Summary

A case of schizophrenia, hebephrenic type complicated by rheumatic heart disease is presented. This case is then briefly discussed as a reflection of juvenile schizophrenia generally. The bizarre picture is presented as an illustration of the schizophrenic process.

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AMERICAN ACADEMY OF PEDIATRICS RECEIVES $50,000 GRANT

The American Academy of Pediatrics, through its state chairman, Dr. H. Kent Tenney, Jr., has announced that the academy is in receipt of a three-year grant of $50,000 from the National Foundation for Infantile Paralysis. The fund will be used in support of the continuing program of the Academy's Committee for the Improvement of Child Health directed toward better and more evenly distributed medical care for children throughout the nation—state by state and county by county —Dr. John Hubbard, director of the committee, stated.

The Committee for Improvement of Child Health will translate into terms of effective action the findings of a two-and-a-half year study of child health services just completed by the Academy. The Academy is a national organization of medical specialists in child care. Financed in part by previous grants from the Foundation and its county chapters, the study has determined just what services are available to children from the physicians, dentists, hospitals, and community health agencies in every part of the nation. Also included was an evaluation of pediatric education in all medical schools.

Diverticulosis and Diverticulitis of the Appendix

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SURGICALLY removed appendixes are one of the most common specimens examined in the surgical pathology laboratory. It would seem that, after the many exhaustive anatomic and pathologic studies which have been published, little more can be said. Yet occasionally an unusual specimen is received which leads one to speculate about the relation of the anomaly to the syndrome of acute appendicitis. The following, therefore, not only records the relatively rare condition of diverticulosis of the appendix, but affords some speculations about its relation to the more frequent and serious occurrence of perforations.

Report of a Case

L. A., a 43 year old white male farmer, was admitted to the surgical service with the chief complaint of abdominal pain. For many years he had experienced intermittent attacks of dull abdominal pain lasting several hours and usually initiated by riding on a tractor or rough road. Five days before admission, he began to have lower abdominal pain. This persisted during his waking hours and was accentuated by movement but not by food ingestion. There was no nausea or vomiting. The pain became more sharp and localized in the right lower quadrant on the day of admission.

Physical Examination.—The patient was in acute distress. The pulse was 82 and the temperature was 98.8 F. There was tenderness in the right lower quadrant, maximal over McBurney's point. There was no spasm or rebound tenderness, and flexion of his right thigh on the abdomen did not increase the pain. No masses could be palpated. Rectal examination revealed tenderness in the right lower quadrant.

Laboratory Findings.—The urine was normal. Examination of the blood showed a white blood cell count of 8,300 per cubic millimeter, with a differential count of 55 per cent polymorphonuclear neutrophiles, 2 per cent stab forms, 35 per cent lymphocytes, 1 per cent eosinophiles, and 7 per cent monocytes. The impression preoperatively was subacute appendicitis.

An appendectomy was performed by Dr. Charles Vedder. The appendix was seen to be thickened and injected throughout, with the distal one-half being studded with soft small nodules. There was moderate induration of the proximal one-half, which extended into the cecum for a distance of 1 cm. The regional nodes were not enlarged.

Pathologic Examination.—The specimen consisted of an appendix 7 cm. in length. The serosa was somewhat milky but glistening, with no grossly recognizable fibrin deposit, and showed a prominent network of injected blood vessels. The surface was studded with numerous firm nodules, varying from 3 to 8 mm. in diameter. These appeared to be more numerous on the mesenteric and antimesenteric aspects (fig. 1). On section, the lumen contained thin mucoid material and the wall was interrupted by numerous

Fig. 1.—The appearance of the specimen before sectioning. The diverticula are easily seen. Note the diverticulum at the extreme tip.

diverticula corresponding to the nodules seen on the surface (fig. 2). Proximally, the lumen of the appendix appeared partially occluded by fibrous tissue.

Microscopically, one of the diverticula was composed of all the normal layers of the wall, but the others were of the false type. Although there was diffuse infiltration with polymorphonuclear and mononuclear cells, the inflammatory reaction was

Fig. 2.—Appearance after longitudinal section. The cut was somewhat off-center.

striking in the walls of the diverticula, particularly the largest one, shown in figure 2. Fibrosis of the submucosa at other sites was also noted.

Subsequent Course.—The patient made an uneventful recovery and was dismissed on the sixth postoperative day. In order to rule out diverticulosis of the bowel, a follow-up gastrointestinal barium study was done some time later. This failed to reveal the presence of any other diverticula. Up to the present time, the patient has been asymptomatic.

Comment

The commonly accepted classification of diverticula of the appendix is based on the structure of the wall. A true congenital diverticulum retains all of the layers of the wall, while the acquired diverticulum is merely a herniation of the appendiceal mucosa through the muscularis.

Acquired diverticula are apparently the more common, the incidence varying from 0.26[6] to 0.17 per cent[7] of all appendixes examined. The incidence of true congenital diverticula is very difficult to determine because rigid criteria of classification have not been followed by some authors.

The pathogenesis of the acquired type is not definitely established. The only experimental work reported on this problem was that of Stout in 1923.[5] Using dogs, he demonstrated that, after the wall has been incised down to the mucosa, the mucosa and submucosa are immediately pushed through the operative defect by vigorous contractions of the muscle. If the muscle loses its contractility, no protrusion occurs. He concluded that a defect, congenital or inflammatory, must be present together with some form of intraluminal obstruction which is followed by active muscular contractions. It must be pointed out, however, that he did not succeed in producing permanent diverticula.

Edwards[3] agrees that the predisposing factors are the presence of gaps in the muscularis, either at the points through which the blood vessels pass or due to the weakening of the muscularis as a result of chronic inflammation. He thinks that the exciting factors are passive distention and irregular muscular action. Sauer[7] believes that obstruction of the lumen occurs chiefly as a result of repeated inflammation and that this leads to increased intraluminal pressure due to continued secretion. He suggests that appendiceal hydrops, mococele, and similar conditions are all part of diverticulum formation. The presence of much mucoid material in our specimen would support this view. Moschcowitz[6], in reporting a case, notes that he has not seen acquired diverticula except in the presence of acute inflammation. Dordick[2] states that no evidence of inflammation, past or present, could be found in 7 cases.

True congenital diverticula have been described by several authors.[1, 7] It is not possble to state the actual incidence because not all of the authors presented definite evidence as noted above. It is obvious that the cases are extremely rare.

Although one of the diverticula in our case should be classified as being of the true (congenital) type, the others were apparently of the acquired type, and the predisposing factors of chronic inflammation and obstruction were present. The marked inflammatory reaction in the walls of the diverticula might indicate that the environment was here more suitable for the inflammation to localize, just as is common of diverticula at other sites of the gastrointestinal tract. It is interesting to note that Aschoff[9] pictures miliary perforations which could easily heal to present the appearance of our specimen. It is interesting to wonder how often perforation is preceded by the formation of a small diverticulum, especially in the many cases in which there is obvious obstruction and increased intraluminal pressure. Once the perforation takes place, it would be impossible to observe the previous diverticulum formation. With this possibility in mind, it might be rewarding to study more carefully than usual the acutely inflamed appendixes removed before perforation takes place. If this should prove to be so, it would tend to confirm the prominent role usually assigned to obstruction in the causation of appendical disease.

The possibility that perforation takes place at the site of a diverticulum formed by previous inflammation should be considered, but seems to be ruled out by the extremely low incidence of diverticulosis recorded. The highest reported incidence is 0.26 per cent,[6] and in our experience we have found diverticula only once in, roughly, 4,000 specimens. One would expect that if diverticula predisposed to perforation, one would find them much more often in relatively normal appendixes.

Summary

1. A case of diverticulosis and diverticulitis of the appendix is presented, which appears to have been responsible for the usual syndrome of acute appendicitis.

2. The possible role of diverticulum formation in perforation is discussed.

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Birth, Infant Death, and Stillbirth Data

WISCONSIN 1947

By AMY LOUISE HUNTER, M. D., Dr. P. H.
Madison

AMY LOUISE HUNTER

A graduate of Yale University School of Medicine, Doctor Hunter served a pediatric internship and residency at Babies and Childrens Hospital, Cleveland, and Childrens Community Center affiliated with Yale University School of Medicine, Department of Pediatrics. Since 1935 she has been chief of the Bureau of Maternal and Child Health of the State Board of Health.

FOR A number of years now it has been a routine procedure in Wisconsin to make a detailed study of all birth certificate information in cases in which a maternal death has occurred after a delivery. In this way information has become available on age, parity, month of gestation, fate of previous children, complications of pregnancy and labor, type of delivery, indication for operation, and causes of prematurity. These studies have been a relatively simple matter because such progress has been made in reducing maternal deaths that in 1947 only 87 mothers died from conditions associated with pregnancy or childbirth, a rate of 1.0 per thousand livebirths. Only a decade ago the Wisconsin resident maternal mortality rate was 3.5 per thousand livebirths.

It is a somewhat more difficult problem to analyze the data from 83,907 livebirth and 1,410 stillbirth records and to match the 2,470 infant death certificates with the birth certificates. However, such studies seem indicated as a possible method of finding suggestions that may further help in conserving lives of infants and reducing stillbirths. The Wisconsin infant death rate reached a new low of 29.4 per thousand livebirths in 1947 as compared with 43.5 in 1937. The stillbirth rate was 16.8 in contrast with 23.4 a decade earlier. Future advances must be based on reduction of neonatal deaths and stillbirths and, if possible, the survival of more of the babies born prematurely. Although most physicians and hospitals are familiar with the presently available statistics, the livebirth and infant death data for the past five years is presented in table 1 for review.

The per cent of babies born prematurely has increased but slightly. The per cent of the total deaths occurring before the end of the first year of life has risen to 75.7. It becomes increasingly evident that every bit of information obtainable should be studied for suggestions that may lead to means of reducing premature interruptions of pregnancy and of saving those babies that die just prior to delivery, during labor, or within the first month of life. The rates vary considerably in different parts of Wisconsin, as shown in charts 1 and 2, portraying by counties the infant death rates and stillbirth rates for the past five years. All birth and stillbirth rates are expressed in terms of 1,000 livebirths. An overall reduction can be brought about if each county approaches the state average, but more than this is needed. Every doctor and hospital should seek to better understand the problem and to find new means of further conserving lives.

The doctors have for the most part completed the lower part of the birth and stillbirth certificates. In 1947 only 2.4 per cent of birth and 1.6 per cent of the stillbirth certificates, a total of 2,027, had no information on the lower portion. A limited number of these lacked data because the births occurred in another state. When it comes, however, to match-death certificates, the State Board of Health found 151 cases among the 2,470 infant deaths in 1947 for which no birth record was available.

TABLE 1.—*Wisconsin Live Births and Infant Deaths (Resident Figures)*

	1943		1944		1945		1946		1947	
Total live births	64,250		61,025		60,839		74,144		83,907	
Premature births	3,254		3,226		3,108		4,035		4,842	
% Total live births	5.1		5.3		5.1		5.4		5.7	
Total infant deaths	2,224		1,949		1,890		2,235		2,470	
Infant death rate	34.6		31.9		31.1		30.1		29.4	
Causes of infant deaths	No.	%	No.	%	No.	%	No.	%	No.	%
"Premature birth"	719	32.3	625	32.1	647	34.2	808	36.2	946	38.3
Congenital malformations	367	16.5	327	16.8	320	16.9	362	16.2	374	15.1
Birth injuries	261	11.7	203	10.4	204	10.8	269	12.0	301	12.2
Congenital debility	174	7.8	184	9.4	174	9.2	227	10.2	234	9.5
Broncho pneumonia	204	9.2	154	7.9	160	8.5	129	5.8	168	6.8
Other upper respiratory infections	196	8.8	69	3.5	57	3.0	80	3.6	77	3.1
Diarrhea and enteritis	83	3.7	74	3.8	73	3.9	72	3.2	79	3.2
Accidents	60	2.7	65	3.3	62	3.3	77	3.4	74	3.0
Whooping cough	32	1.4	17	.9	13	.7	21	.9	26	1.0
All others	128	5.8	231	11.9	180	9.5	190	8.5	191	7.7
Total infant deaths	2,224		1,949		1,890		2,235		2,470	
Neonatal deaths	1,483		1,301		1,305		1,648		1,870	
% Total infant deaths	66.7		66.8		69.0		73.7		75.7	

A review of these showed that 96 of the babies died in the first week of life. This would indicate that the doctor failed to file the required certificate of birth. Causes of death included "premature birth," birth injury, congenital malformation, and other diseases peculiar to infancy, all of which would indicate births occurred in the state. Some of the others may have been born outside of Wisconsin. Inconsistencies are shown in other ways also. On 83 death certificates, "premature birth" was entered as a cause of death, although the birth certificate showed the baby delivered at term and made no entry for cause of prematurity.

Since such a large proportion of births now occur in hospitals it is hoped that sufficient study can be made by hospital staffs to find more specific causes than "premature birth" and "congenital debility." Experience in Chicago and elsewhere has shown that the numbers of deaths thus vaguely allocated can be considerably reduced. Birth information could be improved if every attending physician made it a rule to file the required birth or stillbirth certificate immediately after delivering a patient. He is the only one who can accurately supply information on prenatal care and illness or complications that occurred in pregnancy. It becomes especially important in those hospitals where a member of the resident staff or a nurse fills in part of the certificates that the information entered be reviewed to eliminate discrepancies. Such a review should include a check of

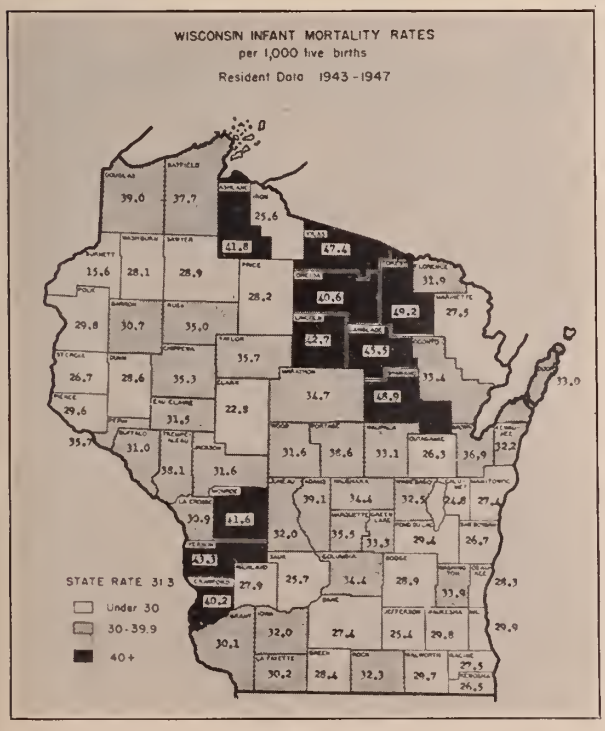

Chart 1

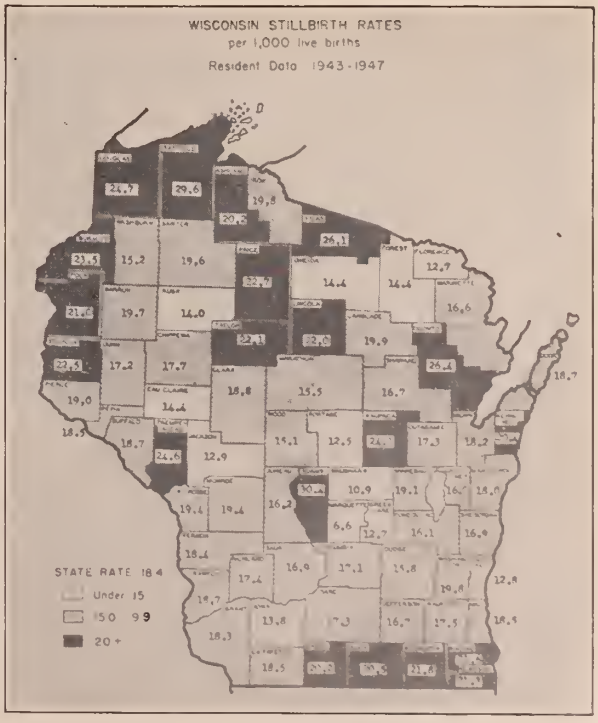

Chart 2

TABLE 2.—*Distribution by Gestation Period—Wisconsin Birth Data—1947*

1947	Total Livebirths		Infants Dying		Stillbirths	
	No.	%	No.	%	No.	%
Unknown	10	0			17	1.2
Previable (Under 7 Mo.)	569	0.7	525	22.6	277	19.6
Viable (7–8½ Mo.)	4, 148	4.9	646	27.9	459	32.6
Term	79, 180	94.4	1, 148	49.5	657	46.6
Total	83, 907		2, 319*		1, 410	

*Does not include 151 infant deaths for which no birth certificate filed.

upper and lower portion entries. Very frequently it is found that a cause of "prematurity" is given when the baby by gestation and by weight must have attained normal term development. A more detailed study was possible for the limited number of death certificates. For the combined study, premature deliveries were selected from the lower portion data rather than on the months of gestation entered. This again accounts for the difference between the numbers reported on table 1 and the other tables.

Until 1947 there were too many gaps in information available from the combined birth and infant-death card to warrant release of special information. During the past year the discrepancies decreased to a point where it seemed worth reviewing the information with the Committee on Maternal and Child Welfare of the State Medical Society. Although elaborate statistical analysis has not been made, the committee requested that the material be released because of the value to doctors and hospitals who may be planning special studies of their own statistics during the coming year. Table 3 shows percentage distribution of selected items by development of the infant.

The per cent of live births occurring in the sixth month or earlier has remained below 1 per cent of total livebirths. The slight increase in the number of premature births which has occurred during the past five years has been in those which had reached at least the seventh month of gestation. Of the 4,717 certificates which showed prematurity, 569 of the patients, or 12 per cent, were delivered prior to the seventh month of gestation. In this group 525, or 92.3 per cent, died. When the gestation period had advanced to 7 to 8½ months, only 15.5 per cent died. In the group reaching term, death took a toll of 1.5 per cent. Of the patients in the group of stillbirths, 46.6 per cent were delivered at term, and more of these were associated with complications of labor than were infant deaths. This group also

TABLE 3.—*Percentage Distribution of Selected Items by Development of Child*

	Previable 6 Mo. or Under			Viable 7th and 8th Mo.			Term Deliveries 8½–9 Mo.			Total		
	Live Births	Infants Dying*	Still-births	Live Births	Infants Dying*	Still-births	Live Births	Infants Dying*	Still-births	Live Births	Infants Dying*	Still-births
Total	569	525	277	4, 148	646	459	79, 180	1, 148	657	83, 907	2, 319	1, 410
Prenatal Care:												
No data or not stated	2.5	3.6	9.0	3.1	4.0	8.7	4.7	2.8	8.8	4.7	3.3	9.4
1st trimester	65.7	66.9	56.0	63.1	59.6	55.3	62.4	58.7	55.0	62.4	60.8	54.8
2nd trimester	24.1	21.7	32.8	20.8	19.7	20.5	23.0	22.3	19.3	22.7	21.4	22.3
3rd trimester or delivery	7.7	7.8	2.2	13.0	16.7	15.5	9.9	16.2	16.9	10.2	14.5	13.5
Parity:												
No data	0.3	0.6	0.4			1.1	0.1	0.1		0.1	0.2	0.5
1st	31.1	32.4	37.2	41.1	33.4	40.3	39.9	35.5	44.1	39.8	34.2	41.4
2 or 3	44.5	44.2	35.7	42.1	45.7	35.7	41.6	38.2	30.6	41.7	41.7	33.3
4 to 7	21.8	21.1	23.1	14.5	18.0	17.4	16.0	21.5	18.4	16.0	20.4	19.0
8 plus	2.3	1.7	3.6	2.3	2.9	5.5	2.4	4.7	6.9	2.4	3.5	5.8
Age of Mother:	**			**			**					
No data		0.8	1.4		0.2	0.4		0.3	1.4	0.1	0.3	1.2
Under 20		10.9	9.8		9.7	6.1		8.7	6.1	7.1	9.5	6.9
20–34		73.5	73.6		78.2	72.1		76.5	70.1	81.2	76.3	71.3
35 or over		14.8	15.2		11.9	21.4		14.5	22.4	11.6	13.9	20.6
Color:	**			**			**					
No data						0.4		0.2	0.7			0.7
White		98.5	97.8		96.9	98.1		96.9	97.3	99.0	97.3	97.5
Negro		1.1	1.5		1.4	1.3		1.2	1.7	0.5	1.3	1.4
Indian		0.4	0.7		1.7	0.2		1.7	0.3	0.5	1.4	0.4

*Included in "Livebirth" column.
**Breakdown of total livebirths not available by gestation.

showed a lower proportion of mothers seeking care early in pregnancy and a relatively higher proportion associated with first pregnancies. In analyzing data according to age of mother, it was found that the same relative proportion of livebirths and stillbirths occurred to women under 20 years of age. However, the proportion of infant deaths assigned to mothers in this age group was slightly greater than the proportion of livebirths assigned to the same group.

Wisconsin has no significant color problem. There were only 441 Negro and 365 Indian livebirths and 21 and 5 stillbirths respectively. The figures are thus too low to influence the over-all state rates.

Pregnancy experience showed that only 7.7 per cent of mothers delivered of liveborn children had prenatal complications. This increased to 23.4 per cent of the cases in which infants died and to 39.9 per cent of cases in which the baby was stillborn. Likewise complications at time of labor appeared in 11.9 per cent of total livebirths, 22.1 per cent of cases in which the infant died and 38.2 per cent of women who delivered stillborn infants.

TABLE 4.—*Per Cent Incidence of Selected Complications of Pregnancy and Labor*

1947 Wisconsin Resident Figures

	Live-births, %	Infants Dying, %	Still-births, %
Prenatal complications			
Bleeding	0.47	5.4	5.9
Hydramnios	0.1	1.9	2.0
Premature rupture	0.14	1.9	2.3
Threatened abortion	0.26	1.8	2.7
Toxemia and eclampsia	1.64	4.2	10.8
Complications of labor			
Breech	1.13	3.2	4.5
Cord complication	0.17	1.0	4.9
Eclampsia and toxemia	0.14	0.5	1.5
Hemorrhage	0.70	4.1	6.5
Premature rupture	0.11	0.8	1.6
Abnormal presentation	1.94	2.5	3.8
Prolonged labor	2.27	2.8	5.0

Although weighted averages have not been been worked out, table 6 compares the ratios with which complications of pregnancy occurred among mothers delivering liveborn infants in relation to those among infant deaths and stillbirths.

The many well trained physicians in Wisconsin for the most part provide excellent prenatal service.

TABLE 5.—*Fate of Child by Complications of Pregnancy and Labor and Type of Delivery*
1947 Wisconsin Resident Figures

	Live-births	Still-births	Total	Infant Deaths,		Infants Stillborn,		Infants Surviving,	
				No.	%	No.	%	No.	%
Total	83, 907	1, 410	85, 317	2, 319*	2.7	1, 410	1.7	81, 588	95.6
Complication of Pregnancy									
None	77, 438	847	78, 285	1, 777	2.3	847	1.1	75, 661	96.6
No data	2, 913	49	2, 962	61	2.1	49	1.6	2, 852	96.3
Toxemia	1, 377	152	1, 529	97	6.3	152	9.9	1, 280	83.8
Bleeding	392	83	475	125	26.3	83	17.5	267	56.2
Renal disease	238	24	262	22	8.4	24	9.2	216	82.4
Threatened abortion	222	38	260	42	16.2	38	14.6	180	69.2
Multiple births	187	4	191	16	8.4	4	2.1	171	89.5
Anemia	140	12	152	7	4.6	12	7.9	133	87.5
Premature rupture	120	32	152	44	28.9	32	21.1	76	50.0
Infectious disease	108	9	117	15	12.8	9	7.7	93	79.5
Hydramnios	83	28	111	44	39.6	28	25.2	39	35.2
Rh factor	91	14	105	15	14.3	14	13.3	76	72.4
Heart disease	83	10	93	4	4.3	10	10.8	79	84.9
Tumors	78	8	86	8	9.3	8	9.3	70	81.4
Diabetes	48	23	71	11	15.5	23	32.4	37	52.1
Other chronic diseases	45	9	54	9	16.7	9	16.7	36	66.6
All other	344	68	412	22	5.3	68	16.5	322	78.2
Complication of Labor									
None	73, 925	871	74, 796	1, 806	2.4	871	1.2	72, 119	96.4
No data	3, 568	76	3, 644	99	2.7	76	2.1	3, 469	95.2
Prolonged labor	1, 904	71	1, 975	66	3.3	71	3.6	1, 838	93.1
Abnormal presentation	1, 625	54	1, 679	58	3.5	54	3.2	1, 567	93.3
Breech	952	63	1, 015	75	7.4	63	6.2	877	86.4
Hemorrhage	590	92	682	96	14.1	92	13.5	494	72.4
Disproportion	409	21	430	12	2.8	21	4.9	397	92.3
Retained placenta	155	4	159	10	6.3	4	2.5	145	91.2
Cord complication	142	69	211	22	10.4	69	32.7	120	56.9
Eclampsia and toxemia	115	21	136	12	8.8	21	15.4	103	75.8
Premature rupture	92	22	114	19	16.7	22	19.3	73	64.0
Multiple birth	79	2	81	8	9.9	2	2.5	71	87.6
Shock	23	2	25	4	16.0	2	8.0	19	76.0
Hydramnios	19	10	29	8	27.6	10	34.5	11	37.9
Ruptured uterus	2	8	10		0.0	8	80.0	2	20.0
All other	307	24	331	24	7.3	24	7.3	283	85.4
Type of Delivery									
No data	2, 004	21	2, 025	49	2.4	21	1.0	1, 955	96.6
Spontaneous	58, 529	1, 017	59, 546	1, 709	2.9	1, 017	1.7	56, 820	95.4
Cesarean	2, 433	77	2, 510	171	6.8	77	3.1	2, 262	90.1
Low forceps	17, 084	91	17, 175	189	1.1	91	0.5	16, 895	98.4
Other forceps	2, 123	70	2, 193	69	3.1	70	3.2	2, 054	93.7
Version and extraction	895	98	993	100	10.1	98	9.9	795	80.0
Induced labor	62	4	66	2	3.0	4	6.1	60	90.9
Operation—type not stated	681	25	706	18	2.5	25	3.5	663	94.0
Other	96	7	103	12	11.7	7	6.8	84	81.5

*Does not include 151 infant deaths for which no birth certificate filed.

There remains, however, the need to increase the number of expectant mothers who report early and regularly to the doctor and to reemphasize the importance of reporting danger signals. Partly because of the old-wives' tales circulating, many early signs are ignored. Correlating medical service with that of the local public health nurse has proved effective in many parts of the state. A home visit by the public health nurse based upon the doctor's report to her offers not only an opportunity for education and demonstration of infant care but an opportunity to report back to the physician early symptoms of developing complications.

Further improvement will depend on learning as much as possible from local experience through study of hospital cases. Consultation prior to operative procedures becomes as important to the life of the baby as to the mother. More pediatric consultations may improve diagnoses. More frequent autopsies may make it possible to find a more definite diagnosis than "prematurity" or "congenital debility" in many cases. Every hospital also needs to be prepared to provide the baby born prematurely with the special care that it needs. A separate nursery in every hospital with more than ten maternity beds and a staff nurse especially trained and assigned the responsibility for care of the prematures would help in saving these babies.

TABLE 6.—*Ratio By Complication Frequency*

Complication of Pregnancy	Live Infant Birth : Death	Live Still Birth : Birth
Toxemia	1: 2.5	1: 6.8
Bleeding	1:11.3	1:12.6
Renal disease	1: 3.4	1: 5.9
Threatened abortion	1: 6.9	1:10.2
Multiple birth	1: 3.1	1: 1.3
Anemia	1: 1.8	1: 5.1
Premature rupture	1:13.2	1:15.9
Infectious diseases	1: 5.0	1: 4.9
Heart disease	1: 1.7	1: 7.2
Diabetes	1: 8.3	1:28.2
Other chronic diseases	1: 7.3	1:11.9
Tumors	1: 3.7	1: 6.1
Hydramnios	1:19.1	1:20.2
Rh mother	1: 5.9	1: 9.1

WISCONSIN CHAPTER OF AMERICAN COLLEGE OF CHEST PHYSICIANS TO MEET

The fourth annual meeting of the Wisconsin Chapter of the American College of Chest Physicians will be held at the Hotel Schroeder, Milwaukee, on October 3, the day preceding the Annual Meeting of the State Medical Society. There will be no registration fee, and all physicians are invited to attend the program, which will be as follows:

1:30 p. m.: Registration, Crystal Ball Room

2:00 p. m.: Scientific Session

"Pneumoconiosis, Pulmonary Emphysema, and Cor Pulmonale"
Norbert Enzer, M. D., F. A. C. P., director of laboratories, Mount Sinai Hospital, Milwaukee; consultant in industrial medicine

"Pulmonary Function in Bronchial Disease"
Edwin R. Levine, M. D., F. C. C. P., F. A. C. P., director of chest service, Michael Reese Hospital; medical director, Winfield Sanatorium, Chicago

"Bronchiectasis, Its Diagnosis and Surgical Treatment"
William A. Hudson, M. D., F. C. C. P., associate professor of clinical surgery, Wayne University College of Medicine; attending surgeon, Detroit Tuberculosis Sanatorium, Detroit

"Comparison of the Effect of Penicillin, Sulfadiazine, and the Combination of Penicillin and Sulfadiazine in the Treatment of Lobar Pneumonia"
Italo F. Volini, M. D., F. C. C. P., F. A. C. P., professor of medicine and chairman of the department of medicine, Loyola University School of Medicine, Chicago

"Fungus Disease of the Lung" (with motion picture demonstration)
Arthur Q. Penta, M. D., F. C. C. P., director, department of broncho-esophagology, Schenectady City Hospital, Schenectady, New York; lecturer, Temple University School of Medicine, Philadelphia

"Pitfalls to the Early Diagnosis of Carcinoma of the Lung"
C. Allen Good, M. D., assistant professor of radiology, Mayo Foundation, University of Minnesota Medical School, and consultant, section of roentgenology, Mayo Clinic, Rochester, Minnesota

6:00 p. m.: Dinner Meeting, Pere Marquette Room
Address: "Protection of Medical and Nursing Personnel in Hospitals"
Jay A. Meyers, M. D., F. C. C. P., F. A. C. P., past-president, American College of Chest Physicians; professor of medicine and public health, University of Minnesota Medical and Graduate Schools, Minneapolis

8:00 p. m.: X-ray Conference, Pere Marquette Room
Address: "Metastatic Tumors of the Lung"
Jerome L. Marks, M. D., roentgenologist, Milwaukee County General Hospital, Wauwatosa

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Bulbar Poliomyelitis

In the care of patients having poliomyelitis, heroic emergency treatment is required for those patients in whom medullary paralysis of the respiratory centers develops. For paralysis of the vasomotor centers, nothing is known to be effective; for vagal paralysis, means should be taken to permit of a free passage of air through the larynx, which is likely to obstruct the free flow of air because of passive apposition of the vocal cords, accumulation of mucus, and complications arising from serious disruption of the complicated reflexes involved in swallowing. When the respiratory centers are involved, pulmonary ventilation demands immediate attention and control, constituting an emergency the beginnings of which in reality have become established before the commonly recognized signs and symptoms of respiratory inadequacy are clearly in evidence.

Very recently there has been demonstrated the fact that when oxygen saturation of hemoglobin is reduced from the average arterial value, namely, of 95 per cent down to 90 per cent, the partial pressure of oxygen in plasma is reduced from 100 to 60 mm. of mercury, which effects a very considerable reduction in supply of oxygen due to the relatively great reduction in the gradient of flow. Since oxygen flows only from a higher to a lower level of pressure, the closer the oxygen tension in plasma approaches the tension in tissues, the lower is the driving force, and hence there follows a reduced inflow of oxygen into the tissues. Cyanosis, commonly thought of as a criterion of deficiency of oxygen, i.e., excess of reduced hemoglobin, is an unsafe guide, since a reduction of saturation of hemoglobin can, under optimal circumstances, be detected by direct observation only when this has fallen to 80 per cent or below. Thus it is clear that there occurs a significant deficiency of oxygen in tissues even at a level not portrayed by changes in the color of the skin or mucous membranes.

It has recently been established that on a sudden reduction of oxygen intake to such an extent that the hemoglobin saturation drops from 95 to 90 per cent, the individual becomes dizzy and soon becomes unconscious. Therefore it is evident that in these cases oxygen deficiency less than enough to produce cyanosis is a distinct liability, especially if prolonged. There is evidence that the frequent occurrence of encephalitic involvement, along with a suspected injury of the respiratory center, may be due to hypoxia, as caused by other disturbances such as bronchial obstruction, spasm of larynx, pulmonary edema of pneumonia, and other interfering conditions preventing free access of oxygen to respiratory surfaces in the lungs, even to disturbed circulation. It is well known that patients with cardiac decompensation frequently manifest psychic disturbances which are evidently manifestations of hypoxia occurring even when the respiratory center itself is not greatly affected. Thus, certain regions of the brain would appear to be more sensitive to hypoxia than is the respiratory center itself, hence the justification of keeping in mind signs of lack of oxygen other than color of the skin or mucous membranes.

These basic concepts concern the care of any of the types of bulbar paralysis which may involve little or much of other parts of the central nervous system. That which is of highest importance is the supply of oxygen to tissues. If cerebral excitation or abnormality occurs, oxygen administered through nasal catheter may reveal the basis thereof. If such a tube cannot be passed through the larynx because of an interfering laryngeal spasm (and this would usually be true), tracheotomy should be done, supplying oxygen in proper concentrations, maintaining the trachea and bronchi free from obstructing materials. Subsequent esthetic disfigurement of the skin of the neck is of small consequence compared to the life of the patient.

The newer evidences relative to the harmful effects of and very possible existence of hypoxia in bulbar poliomyelitis, not reflected either quantitatively or perhaps even qualitatively in cyanosis, lead to the necessity of applying precautionary procedures designed to reestablish, at the earliest possible moment, the normal oxygen saturation of hemoglobin. Artificial respirators, "iron lungs," etc. are of very great importance but appear to be of signal value when all known precautions and measures are taken to get the oxygen saturation of hemoglobin up to normal values. This perhaps can be fairly judged by the psychic condition of the patient, but best by determining the ratio of reduced to oxidized hemoglobin in the blood stream. When it is found that the hemoglobin is saturated to the accepted normal value of 95 per cent, then little more than general supportive measures appear available at the present state of knowledge concerning the care of these patients.—A. L. TATUM, M. D.

REFERENCE

Minnesota Poliomyelitis Research Commission: Bulbar form of poliomyelitis; therapeutic measures based on pathologic and physiologic findings, J. A. M. A. 135:425–428 (Oct. 18) 1947.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Hyperemia Pregnancy Test in Threatened Abortion

The physician's responsibility in threatened abortion cannot be overemphasized. Attempts to maintain products of conception when the fetus is dead submits the patient to unnecessary discomfort, complications, and expense. On the other hand, if curettage is instituted prematurely (fetus alive), the physician is guilty of performing an unintentional abortion.

In threatened abortion, the integrity of the fetus depends on the condition of the placenta. An ordinary positive pregnancy test by any method (rabbit, mice, rat, South African frog) merely indicates that the placenta is producing chorionic gonadotropic pregnancy hormone, but does not indicate the state of the fetus. Retained placental tissue, if not competely degenerated, invariably yields a positive pregnancy test.

Guterman of Michael Reese Hospital developed a color reaction of pregnandiol, a urinary excretion product of progesterone which is secreted by the corpus luteum and/or the placenta. By daily determination of the amount of pregnandiol in the urine, he was able to predict the outcome of the threatened abortion. Since the progesterone is secreted both by the corpus luteum and by the placenta, the question has been raised whether the pregnandiol test is reliable. Some investigators have not obtained results comparable to those of Guterman. The cost of repeated pregnandiol tests is prohibitive to the average patient.

Zondek recently reported a pregnancy hyperemia titration test in rats that is of immense aid in the management of threatened abortion. The test has a high rate of accuracy up to forty days after implantation of the fertilized ovum.

Rabbits cannot be used because hyperemia does not develop in their ovaries following the injection of pregnancy urine. The hyperemia of mice ovaries is ambiguous, whereas the hyperemia of the ovaries of sensitive strain of rats is distinct. The test is performed by inoculating subcutaneously 4 rats respectively with 4 cc., 2 cc., 1 cc., and 0.2 cc. of urine, and their ovaries are examined eight to twenty-four hours (we prefer sixteen to twenty-four hours) after inoculation. The hyperemia is then reported according to the following table:

Rat 1	Rat 2	Rat 3	Rat 4	Interprctation
+	+	+	+	Fetus alive
+	+	+	—	Fetus in danger, repeat test
+	+	—	—	Fetus dying or may be dead, repeat test
+	—	—	—	Fetus dead

Rat 1, injected with 4 cc. of urine = 250 cc. hyperemia units per liter.
Rat 2, injected with 2 cc. of urine = 500 cc. hyperemia units per liter.
Rat 3, injected with 1 cc. of urine = 1,000 cc. hyperemia units per liter.
Rat 4, injected with 0.2 cc. of urine = 5,000 cc. hyperemia units per liter.

The above table should be used only up to forty days of pregnancy when the titer of hyperemia units reaches about 10,000. From forty to eighty days, there is a peak rise the titer of which may reach over 200,000 hyperemia units; therefore, it is obvious that each cubic centimeter of urine will represent a greater amount of hyperemia units than during the first forty days. Consequently, a drop from 200,000 to 20,000 hyperemia units may indicate a dead fetus, yet all 4 rats according to the method will be positive, thus yielding an ambiguous result. We therefore inoculate 2 rats with the lesser amounts of peak pregnancy urine. If the hyperemia test in these rats is negative, the fetus is considered dead.—S. B. PESSIN, M. D.

REFERENCE

1. Zondek, B., Sulman, F., and Black, R.: Hormonal test for fetal death in disturbed pregnancy, J. A. M. A. 136:965–969 (April 10) 1948.

UNIVERSITY TO PRESENT COURSE IN GENERAL MEDICINE

The University of Wisconsin Medical School is presenting an Intensive Course In General Medicine, October 18–22, at the State of Wisconsin General Hospital and the Medical School in Madison. The subject matter will consist of lectures, didactic work, and ward rounds, and there will be case demonstrations. The maximum registration will be limited to 15 physicians and the minimum number for which the course will be offered is 8 physicians.

Problems of general medical interest such as the anemias, diabetes, dermatologic conditions, pulmonary disabilities, gastrointestinal pathology, newer drugs, and diagnostic methods will be included in the material offered.

This course will be under the general direction of Dr. O. O. Meyer, chairman of the Department of Medicine at the University of Wisconsin Medical School and chief of the medical service at the State of Wisconsin General Hospital. The fee will be $25.00 for the offering, and application should be made immediately to Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Doctor Zintek, a native of Milwaukee, received the degree of M. D. from Marquette University in 1934. In 1947 he received the degree of D. P. H. from the University of Michigan following three years of postgraduate work in epidemiology, during which he also served as a research assistant in the field of poliomyelitis.

A. R. ZINTEK

At its July 31 meeting the Wisconsin State Board of Health took action on revising its minimum requirements for the prevention and control of communicable diseases. This action was taken only after very careful deliberation and analysis of the available evidence. In 1943 a committee was appointed to investigate the problem. This committee was privileged to consult with all of the full time health officers, as well as a committee of the State Medical Society. Practicing physicians and pediatricians were contacted, and they offered valuable suggestions. The recommendations of the American Public Health Association and the American Academy of Pediatrics were carefully followed and formed the basic pattern for the new rules.

All persons interested in the mechanism of transmission of communicable diseases are agreed as to the necessity for segregation of the infectious reservoir. The problem arises as to how this isolation can be most effectively accomplished. Past experience has indicated that the method of placing a placard or quarantine sign on the affected home has not been successful in reducing the incidence of disease. The households in which no physician was called, or families which deliberately hid the occurrence of cases severely handicapped the institution of restrictions. The establishment of a diagnosis in mild or doubtful cases meant the imposition of rather severe restrictions. Many disease categories, such as pertussis, scarlet fever, and poliomyelitis, are characterized by the fact that a large proportion, if not the bulk, of the total reservoir cannot be diagnosed clinically. This suggests that isolation was accomplished only in a very limited number of instances and that a very large portion of infectious persons were not restricted at all. In those instances in which a diagnosis was made and the case duly reported, the sign was tacked on to the home of necessity after the patient manifested frank evidence of the specific disease. During the prodromal period, a time when the disease is very readily transmissible, there was no diagnosis, and therefore no sign on the home and no attempt at isolation.

The basic philosophy of the new regulations takes cognizance of the need for an enlightened, well educated public who will voluntarily put isolation into effect at the first sign of the occurrence of an infectious disease. The aim is that isolation will be accomplished before the delay in waiting for the appearance of a rash or other definite signs. It is recognized that the mother is the key person in the effectiveness of such a program. She must be adequately informed not only that segregation is necessary for the protection of other members of the household and the community, but that effective isolation will avoid the superimposition of a new infection upon an already sick child. The new added infection frequently changes the clinical course into a serious or even fatal disease.

Greater responsibilities will be placed upon the teachers and more emphasis upon the exclusion of sick children from the classroom. Malaise, a cough, slight elevation of temperature, or a sore throat are sufficient evidence to exclude a child without waiting for frank manifestations of a communicable disease.

The physician as always remains the link between the health of the individual and the welfare of the community. His importance rests not only with the rapid sterilization of the infected reservoir but also the guidance and education of the community so that the incidence of infectious disease can be effectively reduced.—ARTHUR R. ZINTEK, M. D., *Director of Preventable Diseases.*

CHICAGO OPHTHALMOLOGICAL SOCIETY ANNOUNCES CONFERENCE

The Chicago Ophthalmological Society has announced that its second annual clinical conference will be held November 29–December 4. Special attention will be paid to the pathology and clinical aspects of glaucoma and retinal diseases. The class will be limited to 50. Further information may be obtained from Miss Maud Fairbairn, 8 West Oak Street, Chicago 10, Illinois.

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIAL » » »

Your Cue, Doctor!

THE formation of the Wisconsin Public Health Council last July sets the stage for one of the most promising developments of many years in the field of community health and welfare. The Council's broad objectives—to protect and promote the public health of the people of Wisconsin—present unlimited possibilities. Its democratic provisions for membership permit properly interested citizens, organizations, societies or associations to contribute to the common goal. Realizing the importance of improved public health, the Council on Medical Service and Public Relations and the general Council of the State Medical Society have given their "unqualified support" to the new Council.

Solving health problems today involves so many complex phases of community life that the job requires multiple cooperation. Good health depends upon good housing, good food, improved sanitation, control and prevention of communicable diseases, pure water supplies, medical and nursing care for all the people, health education, care of the aged and chronically ill and almost every other phase of human living.

In every community there are dozens of groups, each working on one or more problems of health with which it is most directly concerned. There is little or no over-all planning for the whole health field to prevent useless duplication of effort or to coordinate effort when necessary.

The Wisconsin Public Health Council, and more important, the county public health councils which it can help to establish, are the means by which the potentialities of each group can be used to the best advantage. The promises held out by the Wisconsin Public Health Council will be realized only as it is able to stimulate the formation of county health councils. These "grass roots" councils will make real public health progress when lay organizations, specialized health organizations and professional groups work together to bring the full advantages of medical science to their community.

And that's your cue, doctor. Wherever community interest seems to set the stage for the formation of a health council, the physicians should prompt every available organization into action. Wherever a health council is formed physicians should be among the supporting cast. Health councils have been successful for more than thirty years because each group contributes its share and gives every other organization a chance to speak its piece. What a health council will accomplish depends upon the community. The most urgent health needs usually provide the strongest stimulus for the organization of a council. Some of these may be to secure a full-time trained public health officer, sponsor a school health program, establish a full-time health department, secure facilities for the aged and the chronically ill, or improve the health conditions of the county institutions. The possibilities are limited only by the extent to which the community wishes to improve its public health conditions.

The Wisconsin Public Health Council is organized to assist local community projects. If your community does not have a health council, consult with other community groups and organize one. That is your cue, doctor. Will you take it?

. . . . THE PRESIDENT'S PAGE . . . .

Finis

ALMOST twelve months ago I marched on to this page, and now, as all Presidents have, I march off. "Auf Wiedersehen!"

To be President of the State Medical Society not only is an honor which everyone senses but also imposes obligations. It has been my desire to present on this page matters which require the thought and consideration of every doctor. For my last page I present one which is, in my opinion, important to all of us.

Nowadays it is common to see in the press and to hear from the platform and through the radio, discussions emphasizing the need for strong local government. State and federal administrators are emphasizing it; the legislators have done little about it except to supply grants-in-aid. The people are not even thinking about it. They, it appears, are willing and anxious to accept anything that relieves them of the responsibility of citizenship. The question is, can democratic government succeed without strong local government, and can strong local government be developed without the local group assuming a large portion of the responsibility?

If the county or a combination of counties or city-county is accepted as the advantageous unit for the development of local government, then it can be said that this unit is the underpinning of our democratic society and that weakness at this level threatens the whole structure. We are told that this is the situation: county public affairs throughout the state and the nation are handled poorly. A variety of reasons are given for this, but the most cogent is the distribution of authority in smaller units, villages and townships, and that these units are too small for effective government. The proposed legislation to enable counties to construct infirmaries to care for the aged, infirm, and helpless is a case in point. Informed people say, if enacted, it will become another meaningless statute to lie in the graveyard of functionless legislation because the counties are unable to finance a project requiring such a large capital expenditure.

Why are the counties so poor? The explanation runs like this. The only method of raising money is through direct taxation of real estate (homes and farms) and this tax is as high as it can go. This may be true, but it is not the only source from which funds accrue in the county. In some instances all of the tax collected on certain items reverts into the county. In other instances, 60 per cent reverts to the county. An instance is the income tax, which is now the largest source of income in the state. One would naturally think with funds in these amounts reverting to the county that there would be money enough to adequately finance a well organized government. However, further examination shows that this money does not go to the county itself but is diffused into smaller units—villages and townships. The county cupboard is left bare—only 10 per cent of the reverted income tax goes to the county government. Furthermore, a good deal of the money which is reverted is already encumbered by activities required by state law. All of this has a depleting effect on the county treasury, and thus we find how the strength of the county is dissipated by dividing government into many small groups, and how money may be wasted by ineffective administration. Multiple divisions of county government weaken it, and the result is ineffective expenditure of tax money.

It is apparent, therefore, that the first important consideration for the strengthening of local government is reorganization of county government. This can be accomplished by centralization in the county or some combination of counties and decentralization at the state and federal level. This would give the local units more funds with which to plan its community activities and more responsibility for their enactment and enforcement. Under this system the federal government would retain close cooperation with the state and the state with the local units. It is not possible nor is it desirable to completely separate the higher units of government from the lower units.

Grants-in-aid from the state or federal government are desirable for certain activities which cross state and county lines and involve expenditures for activities of state or nation-wide significance. With strong local governments the higher units would participate with them in an advisory and consulting capacity and would provide certain services that are not feasible for the local units.

He who holds the purse strings rules. Either we will have weak local government, which means centralized federal government, or we will have strong local governments, which means democratic government. When we rail against federal and state aids, it should be remembered that we are not going to stand still. If local government does not have the money to provide for effective administration, the money will be made available from other sources; facility for progress there will be. Opposition per se availeth nothing. At this moment the nation needs constructive thinking to exercise the rights of free citizens. That decisive power and that alone will secure our institutions and our people from the threat of too much centralized power in the higher brackets of government.

W D Stovall

E. R. SCHMIDT
Madison

C. F. MIDELFORT
Chairman, La Crosse

J. M. FREEMAN
Wausau

THE COUNCIL ON SCIENTIFIC WORK

W. S. MIDDLETON
Madison

IS PLEASED TO PRESENT THE COMPLETE AND OFFICIAL PROGRAM OF THE 1948 ANNUAL MEETING

J. S. HIRSCHBOECK
Milwaukee

MILWAUKEE, WISCONSIN—OCTOBER 3-4-5-6

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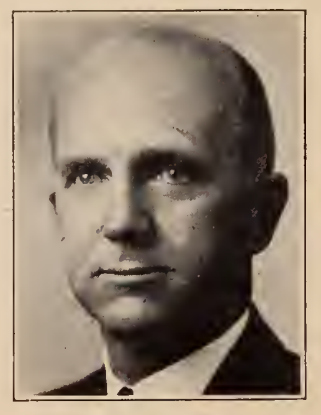

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OFFICIAL PROGRAM

STATE MEDICAL SOCIETY OF WISCONSIN

Official Annual Meeting Notices

■ ADMITTANCE BY BADGE ONLY: Participation in the Annual Meeting is limited to paid members of the State Medical Society of Wisconsin and certified guests. Secure your badge and program at the registration desk in the Milwaukee Auditorium before the scientific sessions begin. If you lose your badge another may be secured.

■ CERTIFIED GUESTS: Arrangements have been made with the hospitals to admit interns and key hospital personnel as guests *if previously certified*. Residents will be admitted only if they are resident members of the State Medical Society and the society of the county in which they reside as a resident. Out-of-state physicians who are full dues-paying members of their county and state medical societies can secure guest badges by presenting their membership cards.

■ REGISTRATION: All those attending scheduled scientific sessions must register at the registration desk in the main arena of the Milwaukee Auditorium. If you attend the clinical conference on Monday morning, you may delay registration until after lunch, but be sure to register before 2:30 p.m., so you can participate in the afternoon scientific session in Plankinton Hall of the Milwaukee Auditorium.

If you are not attending one of the clinical conferences, register in the Milwaukee Auditorium during the morning, and spend the time until your noon luncheon visiting the exhibits.

■ TELEPHONE SERVICE: All physicians attending the Annual Meeting are reminded to tell their home and office secretary how they can be reached during their attendance in Milwaukee. Delegates can be reached during session hours (Sunday, October 3: 1:30–5:00 p.m.; Monday, October 4: 6:00–8:30 p.m., and Tuesday, October 5: 9:00–10:00 a.m.) through the extension phone on the fifth floor of the Hotel Schroeder (Marquette 8–7250). Out-of-town physicians attending the scientific sessions at the Milwaukee Auditorium, Monday between 2:30–5:00 p.m., Tuesday from 9:30–11:30 a.m. and 2:30–5:00 p.m., and Wednesday the same hours as Tuesday can be reached through the registration desk at the Milwaukee Auditorium by calling Daly 8–5920 or Daly 8–5921. Milwaukee physicians should call the Physicians Service Bureau (Marquette 8–4131), and calls will be directed to a special phone in the Auditorium located near the main meeting hall.

■ SPECIAL CONCURRENT EVENTS: The Wisconsin Chapter of the American College of Chest Physicians will hold a scientific meeting on Sunday afternoon, October 3, in the north half of the Crystal Ballroom of the Hotel Schroeder. A dinner will be served in the Pere Marquette Room at 6:00 p.m., and a concluding scientific session will be held in the same room immediately after dinner.

The Marquette University School of Medicine Alumni Association will hold a dinner in the Pere Marquette Room of the Hotel Schroeder Monday evening, October 4 at 6:00 p.m. Principal speaker will be Dr. John S. Hirschboeck, dean of the Marquette University School of Medicine. Up until Monday noon, October 4, tickets can be secured by contacting the Marquette University Alumni Association, 1533 West Wisconsin Avenue, Milwaukee 3.

The Loyola University School of Medicine Alumni of Wisconsin will hold a dinner in Parlor C, fourth floor of the Hotel Schroeder at 6:00 p.m., Monday, October 4. Reservations can be made up until October 1 by writing the office of the president, Loyola University, 706 South Wolcott, Chicago, Ill. Tickets will be available at the registration desk on Monday morning until 11:00 if you have not made your reservation by mail.

The Wisconsin State Medical Golf Association will hold its annual tournament and banquet on Wednesday, October 6, at the Merrill Hills Country Club, Waukesha. The tournament starts at noon, and the banquet will be at 6:30 p.m. There will be entertainment and distribution of prizes at the banquet. Those interested in participating, who have not as yet registered for the tournament, should contact Dr. G. R. Love, Oconomowoc.

■ RESERVATIONS FOR ROUND-TABLE LUNCHEONS: Because of hotel requirements we must make all reservations for luncheons and dinner in advance. Round-table luncheons are limited to twenty-five, and the obstetric luncheons are limited to forty. If at all possible, make your reservations before coming to Milwaukee, but if you have not done so be sure to make your reservations at the time of registration. Tickets are available at the registration desk between 8:00–11:00 a. m. daily, and on Monday and Tuesday between 2:30 and 5:00 p. m. In case you arrive in Milwaukee and have left your tickets at home please secure duplicates at the registration desk. You cannot be admitted to a luncheon without your ticket.

■ SPECIAL LUNCHEONS: Attention is directed to several luncheons which are in somewhat a different category than the rest of the luncheons scheduled during the Annual Meeting:

Past Presidents' Luncheon: Monday, October 4; Parlor G, fourth floor, Hotel Schroeder. Complimentary luncheon for all past-presidents of the State Medical Society.

County Secretaries' Luncheon: Monday, October 4; Parlor A, fourth floor, Hotel Schroeder. Informal discussion of non-scientific character. Members of the State Medical Society staff will be in attendance. Dr. F. L. Grover, Hartland, will serve as chairman. All county secretaries are urged to attend.

Radiologists: The Wisconsin Radiologic Society members will meet at a special luncheon in Private Dining Room C, fifth floor, Hotel Schroeder, Wednesday noon, October 6. There will be an important business meeting as well as a general discussion of the "Economic Problems of Radiology." Dr. B. R. Kirklin, Rochester, Minn. will be a special guest for this luncheon.

Pathologists' Luncheon: The Wisconsin Society of Pathologists will meet in Private Dining Room D, fourth floor, Hotel Schroeder, Wednesday noon, October 6. Dr. W. B. Wartman, Chicago, will be guest discussion leader. The meeting will be under the chairmanship of Dr. W. A. D. Anderson, Milwaukee.

EENT Luncheon: Wednesday noon, October 6 in the Banquet Room, fifth floor, Hotel Schroeder. No limit on attendance. All those who will participate in the section meeting on Ophthalmology and Otolaryngology Wednesday afternoon are urged to attend this luncheon as Dr. F. A. Davis will show his film on "Cataract Operations" following the luncheon, and conclude his discussion during the afternoon session held in the same room as the luncheon.

■ OBSTETRIC MANIKIN DEMONSTRATIONS: A discussion of delivery problems and technics, with the use of the manikin provided through the Bureau of Maternal and Child Health of the State Board of Health, will be incorporated as a part of special luncheons held on each of the three days of the Annual Meeting, in the Pere Marquette Room, fifth floor, Hotel Schroeder. The demonstrations will be conducted following the luncheon scheduled for each day, as listed on the luncheon schedules. Demonstrations will be determined by questions and requests of those in attendance, but generally each demonstration will be devoted to an explanation of the use of forceps and the indications and contraindications for their use, including the management of occiput posterior and the various methods of treating this presentation. There also will be a discussion of the managament of breech presentation and a demonstration of the various methods of delivery as well as version and extraction.

The discussion leaders and demonstrators for each of the three days are:

D. M. Britton, M. D., Madison: Monday, October 4
F. L. Stoddard, M. D., Milwaukee: Tuesday, October 5
R. L. Cowles, M. D., Green Bay: Wednesday, October 6

■ MEDICAL MOTION PICTURES: A full day's program of interesting medical motion pictures has been provided, and will be shown in a room adjacent to Plankinton Hall on the second floor of the Milwaukee Auditorium. Detailed information on the films and the projection schedule will be found on page 889.

■ VISIT THE EXHIBITS: In keeping with established custom, half-hour recess periods have been provided each day, during which time those attending the Annual Meeting are urged to visit the scientific and technical exhibits.

■ SESSIONS OF THE HOUSE: All delegates are requested to plan their affairs so that they may attend the opening session of the House of Delegates on Sunday afternoon, October 3, at 1:30 p. m. in the Banquet Room, fifth floor of the Hotel Schroeder. A buffet dinner will be provided delegates so that the first session can be concluded on Sunday evening. The second meeting of the House will be at 6:00 p. m., Monday, concluding in time for the smoker; and the final session will be held at 9:00 a. m., Tuesday. Registration is required for all sessions, so that an accurate record of attendance can be kept.

■ CLINICAL CONFERENCES: The Council on Scientific Work has provided three clinical conferences to constitute the scientific program for Monday, October 4. These conferences are purposely being held in hospitals so that patients can be used in connection with various papers. A great deal of effort has been made by the staffs of Children's Hospital, Milwaukee County Hospital, and Veterans Hospital to make these meetings of practical teaching value. All sessions will begin at 9:00 and will conclude at 11:30 a. m., so those in attendance can return to the Hotel Schroeder for noon round-table luncheons.

Bus transportation for those who have designated their need will be provided. Buses have been chartered to transport physicians to Veterans Hospital and Milwaukee County Hospital. *No transportation will be provided for Children's Hospital,* as there is adequate bus service between downtown Milwaukee and the Hospital, which is located at Seventeenth Street and West Wisconsin Avenue.

Those attending conferences at Veterans Hospital and Milwaukee County Hospital, *if you have requested bus service:* Buses will be at the Fifth Street entrance of the Hotel Schroeder at 8:00 a. m. Buses will leave the hotel promptly at 8:15 a. m. and will leave the site of the clinic at 11:30 a. m., returning you to the Hotel Schroeder.

If you are attending the clinic at Children's Hospital: Take any *green* bus going west on Wisconsin Avenue, except the one marked Twelfth Street. All other green buses going west on Wisconsin Avenue will take you to Seventeenth Street, where you will alight and walk one half block north, to the entrance of the hospital.

Annual Meeting Timetable

★ SUNDAY, OCTOBER 3 ★

p. m.
1:30 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder

★ MONDAY, OCTOBER 4 ★

a. m.
7:30 Registration: Main Arena, Milwaukee Auditorium
9:00 Clinical Conferences: Milwaukee Children's Hospital
Milwaukee County Hospital
Veterans Hospital, Wood

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
6:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
8:30 Informal Smoker and Entertainment: Crystal Ballroom, Hotel Schroeder

★ TUESDAY, OCTOBER 5 ★

a. m.
9:00 House of Delegates: Banquet Room, Fifth Floor, Hotel Schroeder
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
3:30 Recess to View Exhibits
4:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
5:30 President's Reception for those attending Annual Dinner: Banquet Room, Fifth Floor, Hotel Schroeder
6:45 Annual Dinner: Crystal Ballroom, Hotel Schroeder

★ WEDNESDAY, OCTOBER 6 ★

a. m.
9:00 General Scientific Session: Plankinton Hall, Milwaukee Auditorium
10:10 Recess to View Exhibits
10:40 General Scientific Session: Plankinton Hall, Milwaukee Auditorium

p. m.
12:15 Round-table Luncheons: Hotel Schroeder
2:30 Section Meetings: Milwaukee Auditorium
General Practice: Engelmann Hall
Internal Medicine: Plankinton Hall
Obstetrics & Gynecology: South Juneau Hall
Ophthalmology & Otolaryngology: Banquet Room, Hotel Schroeder
Pediatrics: North Kilbourn Hall
Radiology: Walker Hall
Surgery: South Kilbourn Hall

MONDAY, OCTOBER 4

9:00–11:30 a. m.

1. PEDIATRIC CLINIC—CHILDREN'S HOSPITAL : 721 No. Seventeenth St.

Program arranged by Francis R. Janney, M. D., Wauwatosa

Chairman and Coordinator: John L. Garvey, M. D., Milwaukee

"Neurological Conditions in Infancy and Childhood—Medical and Surgical":

"Medical Aspects, Especially the Meningitides": F. J. Mellencamp, M. D.
"The Outlook and Indications for Surgery of Meningocele": A. A. Schaefer, M. D.
"Subdural Hematoma": Harry P. Maxwell, M. D.
"Brain Abscesses and Brain Tumors": Harry Cleveland, M. D.
"Convulsions": M. G. Peterman, M. D.

Patients will be presented to coordinate the presentations of the above topics.

2. MILWAUKEE COUNTY HOSPITAL CLINIC : 8700 West Wisconsin Ave.*

J. M. King, M. D., and F. D. Murphy, M. D., chairmen

9:00– 9:30 a. m. **"Diseases of the Liver"**
"Diagnosis and Medical Management"—Merle C. F. Lindert, M. D.
"Surgical Management"—James G. Garland, M. D.

9:30–10:00 a. m. **"Peptic Ulcer"**
"Medical Management"—Joseph Shaiken, M. D.
"The Surgery of Its Complications"—Conde F. Conroy, M. D.

10:00–10:30 a. m. **"Peripheral Vascular Diseases"**
"Medical Aspects"—Joseph W. Rastetter, M. D.
"Surgical Management"—Joseph J. Gramling, M. D.

10:30–10:45 a. m. **"Present Status of Colonic Surgery"**—Joseph M. King, M. D.

10:45–11:00 a. m. **"The Proper Use of the Diuretics"**—Francis D. Murphy, M. D.

3. VETERANS HOSPITAL : West National Ave., West Allis*

Maurice Hardgrove, M. D., chairman

9:00– 9:20 a. m. **"Thoracic Amebiasis"**—Mischa J. Lustok, M. D., and Mark W. Garry, M. D.

9:20– 9:40 a. m. **"Diabetes Mellitus"**—B. J. Peters, M. D., and Maurice Hardgrove, M. D.

9:40–10:00 a. m. **"Peripheral Vascular Disease"**—Robert A. Frisch, M. D., and Ralph T. Cunningham, M. D.

Forrester Raine, M. D., chairman

10:00–10:20 a. m. **"Thrombophlebitis"**—James M. Sullivan, M. D., and Howard L. Correll, M. D.

10:20–10:40 a. m. **"Peptic Ulcer: Surgical Treatment"**—Charles M. Schroeder, M. D.

10:40–11:00 a. m. **"Plastic Principles of Use in General Surgery"**—William H. Frackelton, M. D.

* Buses for Milwaukee County Hospital and Veterans Hospital will leave Hotel Schroeder promptly at 8:15 a. m., and will return at 11:45 a. m., in time for noon luncheons. *Advance reservations required!*

MONDAY, OCTOBER 4

12:15–2:15 p. m.: ROUND-TABLE LUNCHEONS—See page 887

2:30–5:00 p. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

N. H. TOPPING, M. D.

E. A. GRAHAM, M. D.

H. W. BROSIN, M. D.

E. R. SCHMIDT, M. D., Chairman

2:30– 3:00 p. m.: "Research Progress on the Common Cold": NORMAN H. TOPPING, M. D., U. S. Public Health Service, National Institute of Health, Bethesda, Maryland, and adjunct professor of medicine, George Washington University School of Medicine; professorial lecturer, Georgetown University School of Medicine, Washington, D. C.

3:00– 3:30 p. m.: "Carcinoma of the Lung": EVARTS A. GRAHAM, M. D., professor of surgery, Washington University School of Medicine, St. Louis (lecture sponsored by Wisconsin Division of the American Cancer Society)

3:30– 4:00 p. m.: RECESS TO VIEW EXHIBITS

4:00– 4:15 p. m.: "Rheumatic Fever — Its Early Diagnosis": S. F. MORGAN, M. D., associate professor of pediatrics, Marquette University School of Medicine, Milwaukee

4:15– 4:30 p. m.: "Rheumatic Fever — Its Treatment": C. M. KURTZ, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

4:30– 5:00 p. m.: "Emotional Aspects of Organic Diseases": H. W. BROSIN, M. D., professor of psychiatry, University of Chicago, The School of Medicine, Chicago (lecture sponsored by the Mental Hygiene Division, State Board of Health)

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MEDICAL MOTION PICTURES: COMMITTEE ROOM "D," MILWAUKEE AUDITORIUM

(Projection room across hall from Plankinton Hall)

2:30– 3:10 p. m.: The Fenestration Operation for Otosclerosis
3:10– 3:30 p. m.: The Feeling of Rejection
3:30– 4:00 p. m.: RECESS TO VIEW EXHIBITS
4:00– 4:40 p. m.: Aortic Pulmonary Anastomosis for Congenital Pulmonary Stenosis
4:40– 5:00 p. m.: Routine Admission Chest X-Rays in General Hospitals

(See page 889 for full description of the films to be shown)

Monday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor B: SURGICAL CONDITIONS OF THE LUNGS: E. A. Graham, professor of surgery, Washington University School of Medicine, St. Louis, Missouri.

2. Parlor C: NEWER DRUGS AND THEIR USAGE: W. S. Middleton, professor of medicine and dean of the University of Wisconsin Medical School, Madison.

3. Parlor D: THE COLLABORATIVE ROLE OF THE FEDERAL GOVERNMENT IN MEDICAL RESEARCH: N. H. Topping, Federal Security Agency, U. S. Public Health Service, Bethesda, Maryland.

4. Parlor E: TREATMENT PROBLEMS IN EMOTIONAL DISORDERS: H. W. Brosin, professor of psychiatry, University of Chicago Medical School, Chicago.

5. Parlor F: RHEUMATIC HEART DISEASE: C. M. Kurtz, associate professor of medicine, University of Wisconsin Medical School, Madison; and S. F. Morgan, associate professor of pediatrics, Marquette University School of Medicine, Milwaukee.

6. Parlor H: ACUTE EMERGENCIES IN PEDIATRICS: F. R. Janney, professor of pediatrics, Marquette University School of Medicine, Milwaukee.

7. Parlor I: GASTROINTESTINAL BLEEDING—ITS CAUSES AND TREATMENT: J. M. King, associate professor of surgery, Marquette University School of Medicine, Milwaukee.

SPECIAL LUNCHEONS

8. Parlor A: County Secretaries' Luncheon (by invitation only).

9. Parlor G: Past Presidents' Luncheon (by invitation only).

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FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: SURGICAL LESIONS OF THE ESOPHAGUS: Forrester Raine, associate professor of surgery, Marquette University School of Medicine, Milwaukee.

11. Private Dining Room C: ALLERGIC DISEASES: T. L. Squier, clinical associate professor of medicine, Marquette University School of Medicine, Milwaukee.

★

OB MANIKIN DEMONSTRATION

12. Pere Marquette Room (5th Floor): EMOTIONAL PROBLEMS OF EXPECTANT MOTHERS: D. M. Britton, Madison. (Doctor Britton will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

MAZUR POLISH DANCERS OF MILWAUKEE

THE BLUE AND LESSER SNOW GOOSE

■ HOWARD J. LEE, M. D.

The Monday evening entertainment will conclude with some outstanding color films of migratory flights of the Blue and Snow Geese, as photographed by R. V. Landis, M. D. Doctor Lee of Milwaukee has collaborated with Doctor Landis, by taking still photographs such as the above.

Dances, Movies Featured at Smoker

MONDAY EVENING OCTOBER 4 HOTEL SCHROEDER

Varied Program of Singing, Dances and Unusual Color Movies
W. C. FINN, M. D., Fond du Lac, *Master of Ceremonies*

Light refreshments—8:30–10:30 p. m.—Lots of fun!

Informal "singfest" led by "Marge" Schiff—well known to physicians who have attended Smokers other years.

Folk Dances and Folk Songs: Under direction of Miss Dorothy Endris, Director of Recreation, Milwaukee Public Schools

Color motion pictures of American wild-life: R. V. Landis, M. D., Appleton. Doctor Landis has received wide acclaim for his color photography. He will comment on the pictures as shown.

All physicians and exhibit representatives invited!
No reservations needed.

The Scientific Cinema

H. K. TENNEY

During each of three days of the Annual Meeting medical motion pictures will be shown in Committee Room "D," adjacent to Plankinton Hall of the Milwaukee Auditorium, where all scientific sessions will be held. The medical motion pictures have been chosen by H. Kent Tenney, M. D., Madison, at the direct request of the Council on Scientific Work. In selecting the films for our 1948 Annual Meeting, Doctor Tenney has chosen recent films which are of greatest concern to the general practitioner, and will also serve as ideal teaching films for the many medical students who will attend the scientific assemblies.

THE FENESTRATION OPERATION FOR OTOSCLEROSIS (George E. Shambaugh, Jr., M. D., and Paul Holinger, M. D. Silent, color). This film, produced in 1947 at Northwestern University Medical School and approved by the American College of Surgeons, describes the principle of the fenestration operation by means of animation. It takes up the indications and then depicts the operation on a patient, including the preoperative preparation, and the patient three weeks after operation.

The showing of this film at the 1948 Annual Meeting is of special significance, as Doctor Shambaugh will be guest speaker on the scientific program of the Section on Ophthalmology and Otolaryngology, Wednesday afternoon, October 6.

Times of showing: Monday, Oct. 4: 2:30–3:10 p. m.
Tuesday, Oct. 5: 10:30–11:10 a. m. and 2:30–3:10 p. m.
Wednesday, Oct. 6: 10:30–11:10 a. m.

THE FEELING OF REJECTION (C. G. Stodgill, M. D., produced at McGill University. Sound, black and white). A life history case study of a girl who is afraid to make decisions and act independently. The film illustrates the effects of childhood training and experiences which have led to the lack of self-reliance and feelings of rejection. Readjustment is affected through psychiatric discussions and group psychotherapy. Available for loan through the State Board of Health.

Times of showing: Monday, Oct. 4: 3:10–3:30 p. m.
Tuesday, Oct. 5: 9:00–9:20 a. m. and 3:10–3:30 p. m.
Wednesday, Oct. 6: 9:00–9:20 a. m.

AORTIC PULMONARY ANASTOMOSIS FOR CONGENITAL PULMONARY STENOSIS (W. J. Potts, M. D., and associates, Northwestern University Medical School. Silent, color). The film shows in detail the technic of aortic-pulmonary anastomosis. Each step is dealt with separately, and the actual technic of suture is shown in animation.

Times of showing: Monday, Oct. 4: 4:00–4:40 p. m.
Tuesday, Oct. 5 9:20–10:00 a. m. and 4:00–4:40 p. m.
Wednesday, Oct. 6: 9:20–10:00 a. m.

ROUTINE ADMISSION CHEST X-RAYS IN GENERAL HOSPITALS (Social Security Administration, in cooperation with the University of Michigan Medical School. Sound, black and white). The film shows the advisability of routine chest x-rays on all patients, and demonstrates the routine followed at the University Hospital, Ann Arbor, Mich. The film is of special interest to hospital administrators, radiologists, chest specialists, nurses, x-ray technicians, and administrative personnel of official and voluntary health agencies.

The film is available for loan through the State Board of Health.

Times of showing: Monday, Oct. 4: 4:40–5:00 p. m.
Tuesday, Oct. 5: 11:10–11:30 a. m. and 4:40–5:00 p. m.
Wednesday, Oct. 6: 11:10–11:30 a. m.
(Also shown during recess periods in W. A. T. A. exhibit on stage of the Auditorium, directly behind the registration desk.)

TUESDAY, OCTOBER 5

9:00–11:30 a. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

J. B. YOUMANS, M. D.

H. P. GREELEY, M. D.

ARNOLD GESELL, M. D.

J. M. FREEMAN, M. D., Chairman

9:00– 9:20 a. m.: **"Treatment of Carcinoma of the Prostate Gland"**: JAMES C. SARGENT, M. D., professor of urology, Marquette University School of Medicine, Milwaukee

9:20– 9:50 a. m.: **"The Place of Nutrition in Medical Practice"**: JOHN B. YOUMANS, M. D., dean, University of Illinois College of Medicine, Chicago

9:50–10:10 a. m.: **"The Role of Isotopes in the Treatment of Thyroid Disease"**: EDGAR S. GORDON, M. D., associate professor of medicine, University of Wisconsin Medical School, Madison

10:10–10:40 a. m.: RECESS TO VIEW EXHIBITS

10:40–11:00 a. m.: **"Iatrogenic Disease"**: HUGH PAYNE GREELEY, M. D., department of internal medicine, Lahey Clinic, Boston

11:10–11:40 a. m.: **"A Clinical Science of Child Development"**: ARNOLD GESELL, M. D., professor of child hygiene, Yale University School of Medicine, New Haven, Connecticut

12:15– 2:15 p. m.: ROUND-TABLE LUNCHEONS

F. W. MADISON, M. D., Chairman

2:30– 3:00 p. m.: **"Surgical Complications of Amebiasis"**: MICHAEL E. DEBAKEY, M. D., associate professor of surgery, Tulane University of Louisiana School of Medicine, New Orleans

3:00– 3:30 p. m.: **"Arthritis of the Spine—Diagnosis and Management"**: RICHARD H. FREYBERG, M. D., associate professor of clinical medicine, Cornell University Medical College, New York

3:30– 4:00 p. m.: RECESS TO VIEW EXHIBITS

4:00– 4:30 p. m.: **"Some Aspects of Treatment of Emotional Illness"**: HARRY M. MURDOCK, assistant professor of psychiatry, University of Maryland School of Medicine, Baltimore (lecture presented under sponsorship of the Rogers Memorial as the Theresa Rogers Memorial Lecture on Psychiatry)

4:30– 5:00 p. m.: **"Office Gynecology"**: JOSEPH L. BAER, M. D., Chicago

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MEDICAL MOTION PICTURES: COMMITTEE ROOM "D," MILWAUKEE AUDITORIUM

(Projection room across hall from Plankinton Hall)

9:00– 9:20 a. m.:
3:10– 3:30 p. m.: The Feeling of Rejection

9:20–10:00 a. m.:
4:00– 4:40 p. m.: Aortic Pulmonary Anastomosis for Congenital Pulmonary Stenosis

10:00–10:30 a. m.:
3:30– 4:00 p. m.: RECESS TO VIEW EXHIBITS

10:30–11:10 a. m.:
2:30– 3:10 p. m.: The Fenestration Operation for Otosclerosis

11:10–11:30 a. m.:
4:40– 5:00 p. m.: Routine Admission Chest X-Rays in General Hospitals

(See page 889 for full description of the films to be shown)

Tuesday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor A: GUIDANCE MEASURES FOR HANDICAPPED CHILDREN: Arnold Gesell, professor of child hygiene, Yale School of Medicine.
2. Parlor B: VITAMINS IN TREATMENT: J. B. Youmans, dean, University of Illinois College of Medicine, Chicago.
3. Parlor C: HYPERTENSION: H. P. Greeley, Lahey Clinic, Boston.
4. Parlor D: COMMON FORMS OF NONARTICULAR RHEUMATISM: R. H. Freyberg, associate professor of clinical medicine, Cornell University Medical College.
5. Parlor E: CAESAREAN SECTION: J. L. Baer, Chicago.
6. Parlor F: NEWER DRUGS AND THEIR USE: O. O. Meyer, professor of medicine, University of Wisconsin Medical College.
7. Parlor G: SOME DIFFICULT METABOLIC OR ENDOCRINE PROBLEMS: E. S. Gordon, associate professor of medicine, University of Wisconsin Medical School, Madison.
8. Parlor H: COUNTY AND CITY-COUNTY HEALTH DEPARTMENTS FOR WISCONSIN: C. N. Neupert, director, State Board of Health, Madison.
9. Parlor I: INDUSTRIAL HAZARDS PECULIAR TO WISCONSIN INDUSTRY: E. L. Belknap, Milwaukee.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: SURGERY OF THE SYMPATHETIC NERVOUS SYSTEM: M. E. DeBakey, associate professor of surgery, School of Medicine, Tulane University of Louisiana, New Orleans.
11. Private Dining Room C: ECTOPIC PREGNANCY: Frank Whitacre, professor of obstetrics and gynecology, The University of Tennessee College of Medicine, Memphis.
12. Private Dining Room D: PSYCHIATRIC TRAINING FOR PHYSICIANS IN OTHER FIELDS: H. M. Murdock, assistant professor of psychiatry, University of Maryland School of Medicine.
13. Committee Room: INDUSTRIAL DERMATOSES: H. R. Foerster, associate professor of dermatology, Marquette University School of Medicine, Milwaukee; assistant professor of dermatology, University of Wisconsin Medical School.
14. Pine Room: NASAL ALLERGY: G. E. Shambaugh, Jr., assistant professor of otolaryngology, Northwestern University Medical School, Chicago.

OB MANIKIN DEMONSTRATION

15. Pere Marquette Room (5th Floor): OBSTETRICAL CASE PROBLEMS: F. J. Stoddard, clinical instructor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee. (Doctor Stoddard will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

R. H. FREYBERG, M. D.

M. E. DeBAKEY, M. D.

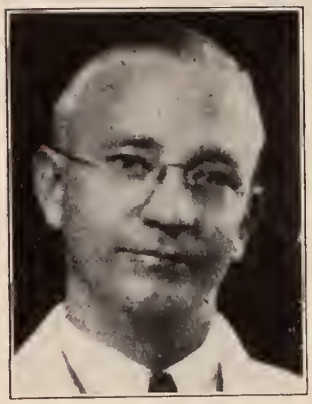
H. M. MURDOCK, M. D.

J. L. BAER, M. D.

WEDNESDAY, OCTOBER 6

9:00–11:30 a. m.: SCIENTIFIC ASSEMBLY — MILWAUKEE AUDITORIUM

K. H. DOEGE, M. D., Chairman



O. H. WANGENSTEEN, M. D.

9:00– 9:20 a. m.: "An Analysis of the Causes of Failures in Fractures of the Neck of the Femur": C. C. SCHNEIDER, M. D., Milwaukee

9:20– 9:40 a. m.: "Changing Concepts in Bowel Surgery": A. C. GORDER, M. D., Milwaukee

9:40–10:10 a. m.: "The Ulcer Problem": OWEN H. WANGENSTEEN, M. D., professor and chief, department of surgery, University of Minnesota Medical School, Minneapolis

10:10–10:40 a. m.: RECESS TO VIEW EXHIBITS

B. R. KIRKLIN, M. D.

10:40–11:10 a. m.: "Cancer of the Stomach": B. R. KIRKLIN, M. D., professor of radiology, Graduate School, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

11:10–11:40 a. m.: "Treatment of Leukemia": CHARLES WATKINS, M. D., associate professor of medicine, University of Minnesota Medical School, Minneapolis, and staff member of Mayo Clinic, Rochester, Minnesota

MEDICAL MOTION PICTURES: COMMITTEE ROOM "D," MILWAUKEE AUDITORIUM

(Projection room across hall from Plankinton Hall)

9:00– 9:20 a. m.: The Feeling of Rejection

9:20–10:00 a. m.: Aortic Pulmonary Anastomosis for Congenital Pulmonary Stenosis

10:00–10:30 a. m.: RECESS TO VIEW EXHIBITS

10:30–11:10 a. m.: The Fenestration Operation for Otosclerosis

11:10–11:30 a. m.: Routine Admission Chest X-Rays in General Hospitals

(See page 889 for full description of the films to be shown)

Wednesday . . .

ROUND-TABLE SCIENTIFIC LUNCHEONS

Note: With the exception of the obstetric demonstrations, all luncheons will be limited to 25 participants in addition to the round-table leader. Cost of luncheon, $2.00. During Annual Meeting remaining tickets sold at the registration desk from 8:30–11:00 a. m., and in Fifth Floor Foyer of the Hotel Schroeder from 11:30–12:15. All luncheons start promptly at 12:15 and conclude at 2:00 p. m.

★ HOTEL SCHROEDER ★

FOURTH FLOOR MEETING ROOMS

1. Parlor A: EARLIER RECOGNITION OF ALIMENTARY TRACT MALIGNANCY: O. H. Wangensteen, professor of surgery, University of Minnesota Medical School, Minneapolis.
2. Parlor B: CONVULSIONS IN CHILDREN: F. A. Gibbs, associate professor of psychiatry, University of Illinois School of Medicine.
3. Parlor C: ALLERGY IN PEDIATRICS: W. Ambrose McGee, Richmond.
4. Parlor D: NEWER DRUGS AND THEIR USES: F. D. Murphy, head of the Department of Medicine, Marquette University School of Medicine, Milwaukee.
5. Parlor E: HYPOTHYROIDISM IN CHILDREN: R. L. J. Kennedy, professor of pediatrics, Mayo Foundation, University of Minnesota Medical School, Minneapolis, and on staff of Mayo Clinic, Rochester.
6. Parlor F: LEUKEMIAS: Charles Watkins, associate professor of medicine, University of Minnesota Medical School, Minneapolis, and head, Section on Pediatrics, Mayo Clinic, Rochester.
7. Parlor G: THE PROBLEM OF BENIGN HYPERTROPHY OF THE PROSTATE: Ira R. Sisk, professor of urology, University of Wisconsin Medical School, Madison.
8. Parlor H: HAND INFECTIONS: W. H. Frackelton, Milwaukee.
9. Parlor I: COMMON RECTAL COMPLAINTS AND THEIR TREATMENT: A. C. Gorder, Milwaukee.

FIFTH FLOOR MEETING ROOMS

10. Private Dining Room B: PAPANICOLAOU SMEAR TECHNIQUE AND ITS APPLICATION IN CLINICAL MEDICINE: W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison.
11. Private Dining Room C: ECONOMIC PROBLEMS OF RADIOLOGY: S. R. Beatty, Oshkosh.
12. Pere Marquette Room: THE PATHOLOGY OF CORONARY ARTERY DISEASE: W. B. Wartman, chairman, Dept. of Pathology, Northwestern University Medical School, Chicago. General discussion under direction of W. A. D. Anderson, Marquette University School of Medicine, Milwaukee.
13. Pine Room: NEWER DIAGNOSTIC METHODS: F. W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee.

OB MANIKIN DEMONSTRATION

14. Private Dining Room D: THE EVALUATION OF LABOR: R. L. Cowles, Green Bay. (Doctor Cowles will also be prepared to discuss problems of delivery, with the use of the obstetrical manikin.)

SPECIAL EENT LUNCHEON

15. Banquet Room (5th Floor): J. K. Trumbo, chairman, Wausau. Following luncheon Dr. F. A. Davis will show his motion pictures on CATARACT OPERATIONS, illustrating different methods of incision and closure of the wound.

SECTION MEETINGS

MILWAUKEE AUDITORIUM
2:30–5:30 P. M.—OCTOBER 6

GENERAL PRACTICE

ENGELMAN HALL
Milwaukee Auditorium

WOODRUFF SMITH, M. D.
Chairman

p.m.
2:15 "The Care of Hip Fractures in a Rural Community": R. L. MacCornack, M. D., and R. M. Rogers, M. D., Whitehall

2:35 Discussion

2:50 "Cardiac Irregularities in the Aged": H. P. Greeley, M. D., department of internal medicine, Lahey Clinic, Boston

3:20 Discussion

p.m.
3:30 Recess

3:45 "The Handling of the Menopause Group": H. M. Murdock, M. D., assistant professor of psychiatry, University of Maryland School of Medicine, Towson, Maryland

4:15 Open discussion on purpose and future of Section on General Practice

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INTERNAL MEDICINE

PLANKINTON HALL
Milwaukee Auditorium

ELWOOD MASON, M. D.
Chairman

p.m.
2:15 "Some Aspects of Nutritional Anemias": J. B. Youmans, M. D., dean, University of Illinois College of Medicine, Chicago

2:45 "Treatment of Tuberculosis with Streptomycin": G. C. Owen, M. D., clinical instructor in medicine, Marquette University School of Medicine, Milwaukee

3:05 Discussant: John D. Steele, Jr., M. D., assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

p.m.
3:15 Recess

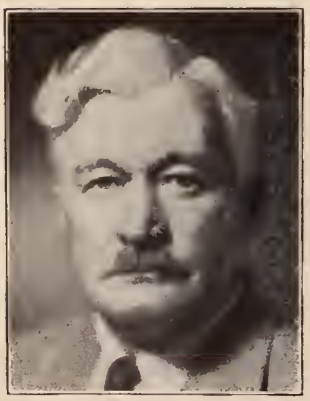
3:40 "Diagnosis of Lymph Node Enlargement": J. S. Hirschboeck, M. D., dean, Marquette University School of Medicine, Milwaukee

4:00 "What Is Rheumatoid Arthritis?": R. H. Freyberg, M. D., associate professor of clinical medicine, Cornell University Medical College, New York City

4:30 Open Discussion

4:50 Business Meeting

★



OBSTETRICS AND GYNECOLOGY

SOUTH JUNEAU HALL
Milwaukee Auditorium

C. S. HARPER, M. D.
Chairman

p.m.
2:15 "The Physiology of the Endocrines as Related to Obstetrics and Gynecology": R. K. Meyer, Ph.D., professor of zoology, University of Wisconsin, Madison

2:35 "The Use of Endocrine Products in Obstetrics and Gynecology": P. F. Schneider, M. D., instructor in obstetrics and gynecology, Northwestern University Medical School, Evanston, Illinois

3:05 Discussant: A. A. Cantwell, M. D., Shawano

3:15 General discussion of previous papers

p.m.
3:35 Recess

3:45 "Eclamptic Toxemia": F. E. Whitacre, M. D., professor and head of department of obstetrics and gynecology, University of Tennessee College of Medicine, Memphis, Tennessee

4:15 Discussant: T. A. Leonard, M. D., Madison

4:25 "Distribution of Whole Blood, Blood Plasma, and Blood Products Through Community Blood Banks": W. D. Stovall, M. D., professor of hygiene, University of Wisconsin Medical School, Madison

GUEST SPEAKERS—SECTION MEETINGS

FRANK WHITACRE
Memphis, Tenn.
Section on Obstetrics and Gynecology

G. E. SHAMBAUGH, JR.
Chicago
Section on Ophthalmology and Otolaryngology

W. A. McGEE
Richmond, Va.
Section on Pediatrics

A. D. PRANGEN
Rochester, Minn.
Section on Ophthalmology and Otolaryngology

R. L. J. KENNEDY
Rochester, Minn.
Section on Pediatrics

F. A. GIBBS
Chicago
Section on Pediatrics

PHILIP SCHNEIDER
Chicago
Section on Obstetrics and Gynecology

WEDNESDAY, OCTOBER 6

OPHTHALMOLOGY AND OTOLARYNGOLOGY

BANQUET ROOM
Hotel Schroeder

J. K. TRUMBO, M. D.
Chairman

p. m.
2:15 "Clinical Allergy for the Nose and Throat Specialists": T. L. Squier, M. D., associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

2:35 Open Discussion

2:45 "The Fenestration Operation: Selection of Cases and Training of the Surgeon": G. E. Shambaugh, Jr., M. D., assistant professor of otolaryngology, Northwestern University Medical School, Chicago

3:15 Open Discussion

p. m.
3:25 Recess

3:35 "The Accommodative and Convergence Factors in Refraction": A. D. Prangen, M. D., associate professor of ophthalmology, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

4:05 Open Discussion

4:15 "The Incision and Closure of the Wound in Cataract Operations": F. A. Davis, M. D., professor of ophthalmology, University of Wisconsin Medical School, Madison

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PEDIATRICS

NORTH KILBOURN HALL
Milwaukee Auditorium

M. G. PETERMAN, M. D.
Chairman

p. m.
2:15 "Exophthalmic Goiter in Children": R. L. J. Kennedy, M. D., professor of pediatrics, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

2:45 "Practical Aspects of Electroencephalography": F. A. Gibbs, M. D., associate professor of psychiatry, University of Illinois College of Medicine, Chicago

3:15 Recess

p. m.
3:30 "Differential Development Diagnosis": Arnold Gesell, M. D., professor of child hygiene, Yale University School of Medicine, New Haven, Connecticut

4:00 "Pediatric Allergy": W. A. McGee, M. D., Richmond, Virginia

4:20 "What the Practitioner May Expect from the Laboratory": Gorton Ritchie, M. D., Milwaukee

4:40 "Some Problems in Roentgenology in Children": J. L. Marks, M. D., clinical instructor in radiology, Marquette University School of Medicine, Milwaukee

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RADIOLOGY

WALKER HALL
Milwaukee Auditorium

S. R. BEATTY, M. D.
Chairman

p. m.
2:15 "Cholecystography": B. R. Kirklin, M. D., professor of radiology, Mayo Foundation, University of Minnesota Medical School, Rochester, Minnesota

2:45 Discussion

3:00 "X-Ray Therapy in Leukemia Cutis": E. A. Pohle, M. D., professor of radiology, and J. H. Juhl, M. D., resident in radiology, University of Wisconsin Medical School, Madison

3:15 "A Pediatric Case Report": H. W. Hefke, M. D., assistant clinical professor of radiology, Marquette University School of Medicine, Milwaukee

p. m.
3:30 Recess

3:45 "Cervical Myelography": S. A. Morton, M. D., Milwaukee

4:00 "Solitary Ulcer of the Colon": H. H. Wright, M. D., assistant clinical professor of radiology, Marquette University School of Medicine, Milwaukee

4:15 "Interpretive Summary of X-Ray Findings in Tuberculosis": A. A. Pleyte, M. D., Milwaukee

4:30 "Adenoma of the Bronchus": L. W. Paul, M. D., professor of radiology, University of Wisconsin Medical School, Madison

WEDNESDAY, OCTOBER 6

SURGERY

SOUTH KILBOURN HALL
Milwaukee Auditorium

F. D. WEEKS, M. D.
Chairman

p.m.
2:15 "Carcinoma of the Ampulla of Vater": K. E. Lemmer, M. D., associate professor of surgery, University of Wisconsin Medical School, Madison

2:35 Discussant: Irwin Schulz, M. D., Milwaukee

2:45 "Present Status of Vagal Resection": P. A. Midelfart, M. D., Eau Claire

3:05 Discussant: Forrester Raine, M. D., associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:15 "Carcinoma of the Breast": C. W. Eberbach, M. D., associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:35 Discussant: J. W. Gale, M. D., Madison

p.m.
3:45 Recess

4:00 "The Surgical Treatment of Colon Malignancy": O. H. Wangensteen, M. D., professor and chief, department of surgery, University of Minnesota Medical School, Minneapolis

4:30 Discussant: E. R. Schmidt, M. D., professor of surgery, University of Wisconsin Medical School, Madison

4:40 "The Surgical Treatment of Peripheral Vascular Disease": M. E. DeBakey, M. D., associate professor of surgery, Tulane University of Louisiana School of Medicine, New Orleans

5:10 Discussant: J. M. Sullivan, M. D., assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

★ SCIENTIFIC EXHIBITS ★

Scientific exhibits have been selected by F. W. Madison, M. D., Milwaukee. The exhibits will be located in the north half of the Main Arena of the Milwaukee Auditorium and on the stage of the Auditorium, directly back of the registration desk. Plan to visit them.

S–8 "Cytological Diagnosis of Cancer"
S–8a

State Laboratory of Hygiene, State Board of Health

This exhibit demonstrates the Papanicolaou method for the recognition of malignant cells in body fluids and exudates. It shows the method of collecting the specimen, preserving it, and forwarding it to a laboratory prepared to do these smears, and the character of normal cells and malignant cells. It illustrates the use of this method for the diagnosis of bronchogenic carcinoma, carcinoma of the cervix and uterus, and malignant disease revealed by the examination of fluid secured from the abdominal cavity, pleural cavity, and urine.

S–9 "Peripheral Vascular Disorders"
S–10

R. A. Frisch, M. D., J. M. Sullivan, M. D., S. S. Zintek, M. D., Maurice Hardgrove, M. D., and Ray Piaskoski, M. D., Veterans Hospital, Wood

This will be a presentation of peripheral vascular disorders that have been reviewed by the Peripheral Vascular Board at the Veterans Hospital, Wood, Wisconsin, composed of members of the departments of medicine, surgery, and physical medicine, with results of various methods of treatment. Illustrations of graphs and kodachrome slides are shown. The use of thermocouple and oscillometer is demonstrated.

S–11 "Demonstration of Pathologic Specimens"

Wisconsin Society of Pathologists

Through the cooperation of various members of the Wisconsin Society of Pathologists, a demonstration of pathologic specimens will be made available with discussion of the lesions. The types of specimens will depend on the material available at the time of the demonstration.

S–12 "Rehabilitation Program for Hare Lip and
S–13 Cleft Palate Children"

W. B. Slaughter, M. D., H. K. Tenney, M. D., W. R. Plater, D. D. S., and N. Glupker, D. D. S., in cooperation with the Bureau of Handicapped Children, State Department of Public Instruction

The exhibit is based on records of incidence and frequency from the State Board of Health. All phases of treatment, including plastic surgery, orthodontia, prostheses, speech, and social service will be demonstrated, as well as the correlation of these services to the fields of pediatrics and anesthesia.

S–14 "Junior League Blood Center of Milwaukee, Inc."

T. J. Greenwalt, M. D., Milwaukee

This exhibit will consist essentially of about 25 charts, measuring approximately 16′ by 22′, describing the growth of the blood center, the procedures used, and the products produced. In addition, there will be a small display of

transfusion equipment and a small box of kodachrome transparencies.

S–14a "Hyperthyroidism—Diagnosis and Treatment.
S–20a Use of Propylthiouracil, Iodine, and Surgery"

Arnold Jackson, M. D., Jackson Clinic, Madison

This exhibit, located directly in front of the registration desk, demonstrates, by the use of colored photography, charts, moulages, and drawings, the various aspects of hyperthyroidism—the diagnosis, the use of iodine and propylthiouracil in the treatment, and the various steps in the surgical removal of goiter. The exhibit calls special attention to the use of propylthiouracil, and colored photographs and charts demonstrate the effect of this drug on cases of hyperthyroidism in children as well as adults. The indication for and against the use of the drug as determined by a study of 175 cases of toxic goiter is discussed.

S–15 "Needle Biopsy of the Liver in Diagnosis of Hepatic Disease"

M. C. F. Lindert, M. D., Milwaukee

Enlarged photomicrographs in color of hepatic diseases diagnosed by means of needle biopsy of the liver are the central theme of the exhibit. In addition, historical data will be printed and actual needles used by several investigators in this field will be shown. A section depicting the use of special diagnostic measures (alkaline phosphatase stain and iron stain) by enlarged color photomicrographs and one pointing out the potentialities of the procedure complete the exhibit.

S–16 "Physical Medicine Rehabilitation Service"
S–17

Ray Piaskoski, M. D., Mr. George M. Reichle, and G. P. Lawrence, M. D., Veterans Administration Center, Wood

A typical rehabilitation service in a Veterans Administration Hospital, showing the integrated program of physical therapy, occupational therapy, corrective therapy, manual arts and educational therapy, social service, recreation and vocational guidance—all designed to aid and motivate the patient to early recovery and restore him to a useful place in his community—will be illustrated.

S–18 "Significant Studies in Radiology"

Section on Radiology, under the direction of S. A. Morton, M. D., Milwaukee

The exhibit will consist of the following displays: "Atelectasis and Collapse", J. L. Marks, M. D.; "Post-operative Cholangiography", H. W. Hefke, M. D., and John L. Armbruster, M. D.; "Routine Fluororoentgen Chest Examinations of Hospital Admissions", A. Melamed, M. D.; "The Response of Intra-thoracic Tumors to Radiation", J. E. Habbe, M. D., H. H. Wright, M. D., and C. E. Schmidt, M. D.; and "Bronchography", S. A. Morton, M. D., and F. W. Thompson, M. D.

S–20 "Pulmonary Resection for Tuberculosis Clin-
S–21 icopathologic Study"

University of Wisconsin Departments of Surgery, Medicine, X-Ray, and Pathology. J. W. Gale, M. D., in charge.

The exhibit shows colored and black and white transparencies of twenty cases of pulmonary resection for pulmonary tuberculosis, covering the known indications. A clinicopathologic study including history, x-rays, gross specimens, and microscopic specimens complete the exhibit.

S–22 "Chemotherapy of Ocular Infections—Sul-
S–23 fonamides and Antibiotics"

J. G. Bellows, M. D., and C. J. Farmer, M. D., Chicago

The exhibit shows the distribution of sulfonamide compounds, penicillin, and streptomycin between the blood and ocular fluids and tissues. A series of experimental extraocular and intraocular infections induced in rabbits' eyes by various organisms is shown by means of transparencies, together with clinical cases. The therapeutic agents employed in this study include the sulfonamide drugs, penicillin, streptomycin, gramicidin, tyrothricin, and bacitracin. The sites of the commoner types of infection are shown diagrammatically, with the drug of choice. Methods of treatment, including corneal baths, with and without ion transfer and intraocular injections, are illustrated.

S–24 "Chemosurgical Treatment of Cancer: A Mi-
S–25 croscopically Controlled Method of Excision"

F. E. Mohs, M. D., Madison

The chemosurgical technic by which the microscopic control of excision is attained is described and illustrated by photographs of patients with lesions in various stages of treatment. Transparencies illustrate the various types of external neoplasms that are amenable to chemosurgical treatment. Pictures of the lesions before, during, and after treatment are included. Reconstructions of cancers show the "silent" outgrowths from the main mass of tumor and emphasize the need for the microscopic control of excision. Charts present the rates of cure in the three year and five year periods.

S–26a "Common Industrial Poisons—Recognition and Control"

E. L. Belknap, M. D., Milwaukee

The exhibit will consist of charts, slides, and microscopic demonstrations covering the subjects of lead, carbon tetrachloride, benzol, and cadmium fumes as examples of toxic dusts, vapors, and fumes affecting industrial workers. The importance of industrial medicine to the general practitioner is emphasized in the exhibit.

S–26 Applied Anatomy
S–27

Department of Anatomy, Marquette University School of Medicine

The exhibit will include two dissections which will show the two venous systems below the diaphragm. One will show the collateral veins about the right kidney and will demonstrate the desirable points of ligation of the inferior vena cava system of veins. The other dissection will demonstrate the anatomy involved in shunting part of the portal venous blood to the inferior vena cava via the left renal vein.

S–28 Neuroanatomy
S–29

University of Wisconsin Department of Anatomy

The chief feature of the exhibit will be a discussion of the brain, spinal cord, and limb plexuses in situ. Sections of the head and brain will be on demonstration as accessory material to the main dissection.

S–30 "How Anti-Vivisection Handicaps Medical Progress"

National Society for Medical Research, Chicago

Information is based on surveys conducted by

the National Society for Medical Research, showing the extent of antivivisection obstructionism, examples of antivivisection propaganda, technics and descriptions of work which the National Society for Medical Research is doing to overcome antivivisection obstructionism.

S–31 "Carcinoma of the Esophagus"
Forrester Raine, M. D., Milwaukee
The exhibit will consist of models of the esophagus and stomach, showing high and low carcinoma of the esophagus and the surgical removal and reconstruction by gastroesophageal anastomosis.

SS–1 "Mycologic Diagnosis"
Esther Meyer, Ph. D., Chicago, and Marvin Kagen, M. D., Appleton
The salient features of the symptoms and signs of the deep and superficial fungus diseases are listed, along with the specific drugs used in therapy. The methods for making mycologic diagnoses are illustrated and described. Colored photographs of the microscopic observations and cutaneous lesions, giant colonies, and anaerobic cultures are presented. The aim will be to the general practitioner an approach to making a diagnosis of a fungus disease.

This exhibit will be located at the foot of the stage directly west of the registration desk.

SS–2 "Siderosis; A Benign Pneumoconiosis Due to Iron Fumes and Dusts"
O. A. Sander, M. D., Milwaukee
This exhibit will be located at the foot of the stage, directly east of the registration booth. It will summarize a 15 year series of periodic chest roentgenograms of eight welders, steel cutters, and grinders, along with the pathologic sections from an additional case. The x-ray findings are characterized by discrete nodular and stippled shadows due to iron oxide deposits in the perivascular lymphatics. Such iron pigmentation is entirely inert, with no resulting fibrosis, impaired lung function, or increased susceptibility to tubercuIosis or other infections. It is of significance only because of its frequent misdiagnosis as silicosis.

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EXHIBITS LOCATED ON STAGE OF AUDITORIUM

ST–1 "Organized Medicine Attacks Cancer"
Committee on Cancer of the Medical Society of Milwaukee County, The Milwaukee County Cancer Detection Center, and the Milwaukee Division of the American Cancer Society
This exhibit is designed to show the benefits of lay and professonal cooperation in attacking the cancer problem. It shows the position of a county medical society cancer committee and its relationship to the many community interests attacking the cancer problem. Statistics, illustrations and organizational outlines will be shown.

ST–2 "Cooperation Afforded Red Cross by Medical Profession"
American National Red Cross
Display pictures depict service given to the public in programs which have been organized at the suggestion of and through the assistance given by the medical profession and demonstrate the cooperation which has been afforded the Red Cross by the medical group.

ST–3 Exhibit of the National Foundation for Infantile Paralysis
ST–4
(See official program for details)

ST–5 "Relief of Hypertension by Sympathectomy"
James E. Conley, M. D., Milwaukee
Relief of the hypertensive state by thoracolumbar splanchnicectomy (Smithwick operation) will be displayed. Relief of the cardiac status will be shown by changes in the electrocardiogram and x-ray studies. There will be a brief note on the effects of sympathectomy, both the desirable and untoward effects.

ST–6 Wisconsin Anti-Tuberculosis Association
ST–7
This will be a presentation of interesting chest x-ray films by WATA physicians, alternating with sound movies, one of which is entitled "Routine Admission Chest X-Rays in General Hospitals." Free literature can be obtained, and educational and informational material may be viewed on the panels.

ST–8 "Health Films Shown to the Public"
Wisconsin State Board of Health
The Wisconsin State Board of Health will show films on "Environmental Sanitation," "Sex Education," "Safety," and "Mental Health." These films are among the many which are available for loan without charge to residents of Wisconsin and which are being used extensively by schools and adult groups throughout the state. A catalog giving a descriptive list of all films available will be distributed at the booth.

ST–9 "The Cancer Problem Today: Early Diagnosis"
ST–10
Wisconsin Division, American Cancer Society
Through a series of photographs, the cardinal signs of cancer are illustrated. Two charts emphasize the responsibility for delay in the diagnosis of cancer. Theme: "With few exceptions the life of the cancer patient is in the hands of the first physician he sees."

ST–11 "Rheumatism: King of Human Misery"
Wisconsin Rheumatism Association
(See official program for details)

ST–12 "The Differential Diagnosis of Congenital Heart Disease"
Gorton Ritchie, M. D., and Francis Rosenbaum, M. D., Milwaukee, for the Wisconsin Heart Association
Examples of congenital cardiovascular disturbances corrected by surgical procedures are presented. These are contrasted with other congenital cardiac lesions from which they may be differentiated. The major diagnostic features of each disorder are outlined.

ST–13 "Cancer in the Medical School Curriculum"
ST–14
Marquette University School of Medicine, Milwaukee
This exhibit is intended to show the manner in which cancer teaching is being correlated through the cooperation of the various departments of Marquette University. The program will be outlined by charts. In addition, there will be slides and photographs relating to breast and cervical cancers. Technics for the development of teaching material will be demonstrated. These technics will be the Papanicolaou smear method, demonstration models, and some aids in photography.

TECHNICAL EXHIBITS

Booth COMPANY AND PRODUCTS

37 Abbott Laboratories, North Chicago, Ill.

Awaiting You Here!
A brand new exhibit specially prepared to excite your interest and attention!
Abbott Professional Service Representatives eager to discuss the newer developments in Abbott products. A hearty welcome!
Make a Visit to Booth No. 37 a **MUST** *on your Technical Exhibit Itinerary.*

47 Ahlstrom Surgical Company, Chicago

The Ahlstrom Surgical Company, a new surgical house in Chicago, will display an unusually complete assortment of high quality instruments. These instruments are selected from the manufacturers who make the best in each specialty. A wide variety of physicians' and office supplies and specialties will also be shown.

60 A. S. Aloe Company, St. Louis
61

The representatives of the A. S. Aloe Company will welcome their friends at booth 60, where they will have on display a representative cross section of our complete line of surgical, hospital, and laboratory equipment and supplies. Featured will be a complete line of government surplus instruments available at the present time—especially selected, fully certified instruments at approximately one-half the regular cost.

73 American Hospital Supply Corporation, Chicago

The following items will be displayed: all Baxter parenteral products—intravenous solutions, including the new *Protein Hydrolysate–Baxter*, blood transfusion and plasma equipment, and disposable accessories for their administration; all blood-grouping serums; *Tomac Oxygen–Nebulizer* for inhalation therapy; and certain selected Tomac products.

6 Ames Company, Inc., Elkhart, Ind.

Ames Company representatives will be glad to discuss *Decholin,* the standard hydrocholeretic agent for the treatment of biliary tract diseases, and *Decholin Sodium,* pure sodium dehydrocholate. Representatives will also demonstrate *Clinitest* and *Hematest,* simplified tests for the detection of urine sugar and occult blood.

67 Armour Laboratories, Chicago
68

The Armour Laboratories, a pioneer in the field of endocrinology, will welcome members of the State Medical Society of Wisconsin to visit the Armour exhibit.
If you have not received your copies of booklets on "The Thyroid Gland," "Function and Malfunction of the Biliary System," and "The Armour ATLAS of Hematology," you may secure them at the Armour booth.

Booth COMPANY AND PRODUCTS

S–7 Audio Development Company, Minneapolis (Cory Hearing Center, Milwaukee)

ADC Audiometers are precision hearing test instruments scientifically accurate and easy to operate, featuring dual receivers on headband which provide for switching of test tone instantly from ear to ear.
The Audio Development Company has maintained a consistent program of research and development to provide the profession with a new and accurate, convenient and dependable method for determining hearing acuity.

66 Ayerst, McKenna & Harrison, New York

Premarin (estrogenic substances—water soluble) a highly effective and well tolerated preparation of naturally occurring, orally active, conjugated estrogens (equine). The potency of *Premarin* is expressed in terms of its principal estrogen, sodium estrone sulfate.
Premarin is available in tablets of four potencies and also in liquid form.

32 Barr X-Ray Company, Milwaukee

Exclusive distributors covering Wisconsin for the F. Mattern Mfg. Co., Chicago, manufacturers of diagnostic and therapeutic x-ray apparatus. Radiographic units made in various models delivering up to maximum of 500 ma. Therapy units with output capacity up to 250 kv., constant potential circuit. The Barr X-Ray Co. is now located in its own building at 1924 W. Clybourn St., Milwaukee 3, Wis.

74 Beech-Nut Packing Company, Canajoharie, N.Y.

Nutritionists will be in attendance to answer any questions regarding the 37 varieties of Beech-Nut strained and junior foods. They will also be happy to describe their nutrition program and will have on hand the charts which they use to teach mothers in various well-baby clinics.

45 Benson Optical Company, Inc., Minneapolis

Hardrx safety lenses for regular wear, *Naturform* plastic artificial eyes, contact lenses, and other ophthalmic products included in our complete service will be displayed.

13 House of Bidwell, Inc., Milwaukee

14

A large variety of surgical and prosthetic appliances will be displayed in our booth, including demonstration of new *Suction Socket Limbs.*

Booth COMPANY AND PRODUCTS

42 Bilhuber–Knoll Corporation, Orange, N.J.

Among the Council-accepted products displayed will be *Bromural*, a daytime sedative and mild hypnotic; *Dilaudid*, an analgesic and cough sedative; a well tolcratcd *Metrazol*, analeptic and antianoxiant; *Thcocalcin*, a diuretic and myocardial stimulant, and other dependable prescription chemicals. All may be prescribed alone or in combinations with other medicinals to meet the needs of the individual patient.

38 Borden Company, New York

We invite your attention to *Protolac*, a new especially-formulated blend of intact proteins and high protein products derived from animal and vegetable sources. *Protolac* is supplemented with choline and the amino acid cystine. *Protolac* is indicated in high protein therapy in conditions rcquiring increased dietary protein of optimum nutritional value. Likewise exhibited will be our long-established products for infant feeding: *Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks,* general purpose *Klim*, and *Beta Lactose.*

15 Brooks Appliance Company, Chicago

Our display will featurc a complete line of bandages, proctologic instruments, syringes, needles, and elastic stockings. Mr. W. C. Ayer will be in charge of the exhibit and will describe in detail the technic of applying the new combination pressure bandages, *Contura plus Pressoplast,* which are uscd in treating phlebitis and leg ulcers.

39 Burroughs Wellcome & Company, New York

Among significant products featured will be *"Wellcome" Globin Insulin,* which provides an action which is timed to be more suitable for the average diabetic; *Dexin* brand *High Dextrin Carbohydrate,* in which the nonfermentable proportion predominates; *Digoxin*, the pure, stable, crystalline glycoside which offers predictable digitalization; and *Methedrine,* a recent sympathomimetic drug of wide therapeutic application.

24 Camel Cigarettes, New York
25

Camel cigarettes will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract.

S–32 Cameron Surgical Supply Company, Chicago

The exhibit will feature a demonstration of the *Cameron Cauterodynes* and *Cauteradios* for Electrosurgery, electrocauterization, and electrocoagulation; *Coagulair-Sigmoidoscope;* electrodiagnostic lamps and instrument sets, radiolucent cannula; the new flexible gastroscopes with treated and coated lenses; flexible esphagoscope; bronchoscopes, esophagoscopes, laryngoscopes; mirror headlites; binocular spectacle loupe; *Magniscope* and other specialties.

71 Carnation Company, Los Angeles

You are invited to vist booth 71 where you will see an attractive display on *Carnation Evaporated Milk*—"the milk every doctor knows." Some valuable information on the use of this milk for infant feeding, child feeding, and general diet will be presented and the method by which Carnation is generously fortified with pure crystalline vitamin D—400 U.S.P. units per reconstituted quart—will be explained. Interesting literature will also be available for distribution.

58 Ciba Pharmaceutical Products, Inc., Summit, N.J.

The Ciba exhibit of "Economical Hormone Therapy" will feature *Metandren* Linguets, the most potent oral androgen in tablets, designed for absorption through sublingual mucosa: *Lutocylol* Linguets, orally effective progestogen especially designed for sublingual absorption; and *Ethinyl Estradiol,* the most potent oral estrogen. Representatives in attendance will gladly furnish literature and answer questions about these and other Ciba products.

30 Coca–Cola Bottling Company, Milwaukee

"Have a Coke" refreshment stand will serve free, ice-cold bottles of *Coca–Cola* to all those attending the meeting.

75 DePuy Manufacturing Company, Warsaw, Ind.

The exhibit of the De Puy Manufacturing Company will feature aluminum splints pervious to x-ray; fracture appliances; bone screws, hip screws, bone plates, 19–9 SMO Type 317, in stainless steel.

56 De Vilbiss Company, Toledo, O.

S–5 Dietene Company, Minneapolis

Visit the Dietene Company exhibit and discover that really palatable high protein diet supplement—*Meritene.* Smell it—taste it—and be convinced. Also see the personal type diet service that is available, without charge, to physicians. *Dietene* Reducing Supplement and the 1,000 calorie *Dietene* Reducing Diet will also be on display.

8 Downs X-Ray Company, Milwaukee

Downs X-Ray Company will exhibit the Profexray Table combination radiographic and fluoroscopic unit. This unit can be used as a standard examining table with a self-contained radiographic unit with built in control and has ample room for film and accessory storage. We will also exhibit the latest in direct writing cardiograph.

72 C. B. Fleet Co., Inc., Lynchburg, Va.

C. B. Fleet Co., Inc. cordially invites you to stop at booth 72 for a short visit with Mr. W. F. McKeon, the representative who sees you in your office about once a year. Perhaps there is something about *Phospho-Soda (Fleet)*, the pure, stable, aqueous concentrate of the two U. S. P. sodium phosphates, you would like to discuss with him. Mr. J. Gordon Myers of Chicago is assisting Mr. McKeon at this meeting.

Booth COMPANY AND PRODUCTS

31 H. G. Fischer & Company, Chicago

The H. G. Fischer & Company invites physicians to see their latest FCC-approved short wave generators, which are of such high quality in design and material that they do not require a complicated system of crystal controls or wave traps in order to function properly. Our complete line also includes many models of shockproof x-ray apparatus, contractural current generators, and ultra-violet lamps.

1 General Electric X-Ray Corp., Chicago

40 Gerber Products Company, New York

51 Health Spot Shoe Store, Appleton, Wis.

Health Spot Shoes present a display of corrective foot wear for men, women, and children, as well as surgical shoes. The importance of body balance and weight distribution is emphasized. The effect of foot imbalance upon body posture is the theme of the display, which shows shoes in the process of manufacture from the last to the finished product. One hundred and thirty-one shops, operated by trained personnel and dedicated to giving *foot comfort*, are exclusive distributors of Health Spot Shoes.

S–4 H. J. Heinz Company, Pittsburg, Pa.

Heinz will be displaying Strained and Junior Foods as well as their wide variety of nutrition material. Doctors will find the products of interest not only for the feeding of babies and other small children but for the feeding in gastrointestinal cases, preoperative and postoperative disturbances, oral troubles, and a number of conditions in which Strained and Junior Foods are required.

70 Hoffmann–La Roche, Inc., Nutley, N.J.

Roche is happy to exhibit at the meeting of the State Medical Society of Wisconsin. They invite members of the Society to visit booth 70, where members of the representative staff will be present to discuss such new products as *Syrup Sedulon*, a sedative cough preparation especially useful for night cough; *Thephorin*, a different antihistamine which is not likely to cause drowsiness; *Presidon*, the mild new sedative-hypnotic which is not a barbiturate and does not cause "hangover"; and other products of interest to physicians.

33 Hurley X-Ray Company, Milwaukee

34

You are cordially invited to visit our booths and our showroom while at the meeting. Our Wisconsin representatives will be present to discuss x-ray and physical medicine equipment and accessories. Several units manufactured by Picker, Burdick, and Rocke, leaders in their respective fields, will be shown at the meeting and at our office. We'll be happy to see you!

Booth COMPANY AND PRODUCTS

S–37 "Junket" Brand Foods, Little Falls, N. Y.

The importance of rennet in infant and adult nutrition and the value of rennet desserts in both normal and restricted diets will be explained. Enlarged photos illustrate the action of the rennet enzyme in producing softer, finer, more readily digestible milk curds. Authoritative literature is available describing dietary applications of rennet products. Complimentary packages of *"Junket" Rennet Powder* and *"Junket" Rennet Tablets* for the profession.

20 E. H. Karrer Co., Milwaukee

21

Serving the medical profession for over forty years, we will show biologic refrigerators, genuine Stille and domestic surgical instruments, autoclaves, basal metabolors, diagnostic instruments, electrosurgical units, cabinet instrument sterilizer, examining room and office furniture, examining and magnifying lamps, short wave diathermies, ultraviolet lamps, office and baby scales, suction and pressure apparatus, penicillin nebulizers, electric centrifuges, tubal insufflators, physicians' bags, and Ritter specialist equipment.

46 Kremers–Urban Company, Milwaukee

Kremers–Urban Company will feature a new form of estrogen therapy, *Estrugenone*. Other Council-accepted pharmaceuticals on display will be *Aminophylline, Diethylstilbestrol, Folic Acid Tablets, Thiamine Hydrochloride Tablets*, etc.

S–33 Laabs, Inc., Milwaukee

The Laabs, Inc., exhibit will consist of a display of pharmaceuticals and physicians' and surgical equipment from well established concerns. Laabs, Inc., is celebrating its fiftieth year of service to physicians of Wisconsin, and we take pleasure in presenting this exhibit to renew acquaintances and to inform other physicians of our comprehensive service.

22 Lakeside Laboratories, Inc., Milwaukee

23

The Lakeside exhibit will feature the mercurial diuretic, *Mercuhydrin*. Representatives will be on hand to describe the use of this modern diuretic in early and late cardiac decompensation and other conditions. This, as well as other Lakeside specialties which will be displayed, have created general interest and medical discussion this year.

64 Langer Laboratories, Inc., Milwaukee

Herman and Jack Langer of Langer Laboratories, Inc. are displaying products of the following manufacturers: Bristol, Ciba, Roche Organon, Hoffman–La Roche, Ames, USSP, Sharp and Dohme, Johnson and Johnson, Winthrop, Lederle.

16 Lederle Laboratories, Inc., New York

You are cordially invited to visit our exhibit in Booth 16, where you will find representatives who are prepared to give you the latest information on Lederle products.

Booth COMPANY AND PRODUCTS

44 Eli Lilly and Company, Indianapolis, Ind

Featured at the Lilly exhibit will be new therapeutic developments. Many Lilly products are to be on display; representative literature will be available. Lilly medical service representatives are to be in attendance to aid visiting physicians in every way possible.

17 J. B. Lippincott Company, Philadelphia

The J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the "pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine are reflected in the Lippincott selected professional books.

S–2 Luzier's Fine Cosmetics, Kansas City, Mo.

A display of Luzier's Fine Cosmetics and Perfumes will be exhibited in Booth S–2. This will be of interest to dermatologists and allergists as well as to the ladies who visit the Convention. Distributors of Luzier's Fine Cosmetics and Perfumes will be on hand to explain Luzier's Service in the field of allergy.

35 M & R Dietetic Laboratories, Inc., Columbus, O.

The M & R Dietetic Laboratories exhibit will display *Similac*, a food for infants derived either partially or entirely of breast milk. Messrs. T. F. Bommer and G. G. Curry will appreciate the opportunity to discuss the merit and suggested application for both the normal and the special feeding cases.

S–38 Maico Midwest Distributors, Milwaukee

The Maico exhibit will feature the famous Maico *Atomeer* hearing aid with invisible hearing, the Maico *D–9 Precision Audiometer*, and the *Stethetron*—Maico's electronic stethoscope.

27 Maltine Company, New York

The Maltine Company will exhibit *Thromboplastin–Maltine*, a sensitive reagent for the determination of blood prothrombin time. You are invited to visit our booth. Have you received your set of memorandum books for 1948 and 1949?

26 Mead Johnson & Company, Evansville, Ind.

Amigen and *Protolysate* will be on display at the Mead Johnson exhibit. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than one hundred and forty articles in the medical literature; this year they are available. Trained representatives will discuss details of the new amino acid products. Shown also will be *Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum*, and the other Mead products used in infant nutrition.

S–1 Medical Protective Company, Fort Wayne, Ind.

The most exacting requirements of adequate liability protection are those of the professional liability field. The Medical Protective Company, specialists in providing protection for professional men, invites you to confer at their exhibit with the representative there, Mr. M. M. Morehart. He is thoroughly trained in professional liability underwriting.

Booth COMPANY AND PRODUCTS

28 Medico–Mart, Inc., Milwaukee
29

Surgical and diagnostic instruments, electrosurgical equipment, sterilizers and autoclaves, short wave and microwave machines, basal metabolism machines, surgical and office lights, ultraviolet lamps and therapeutic equipment, professional furniture and office equipment, hospital supplies and equipment.

65 Wm. S. Merrell Company, Cincinnati

Mercodol, the new antitussive syrup containing the better cough-controlling narcotic, *Mercodinone*, will be featured by Merrell. *Mercodinone*, a better antitussive agent than either heroin or codeine, is notably free from the undesirable side effects of the older drugs. *Mercodol* also contains the bronchodilator, *Nethamine*, and the saline expectorant, sodium citrate.

69 C. V. Mosby Company, St. Louis

A cordial invitation is extended to all physicians to visit the C. V Mosby Company display, where a wealth of new and timely medical literature will be available for examination. Some of the very new releases to be shown will include Grossen "Operative Gynecology," Pottenger "Tuberculosis," Gradwohl "Clinical Laboratory Methods and Diagnosis," Dunbar "Synopsis of Psychosomatic Diagnosis and Treatment," and Ilgenfritz "Preoperative and Postoperative Care."

50 V. Mueller & Company, Chicago

V. Mueller & Co. will display a complete line of surgeons' instruments in addition to Ritter Nose & Throat chair and treatment unit.

11 A. R. Nechin Company, Chicago

The Jones Waterless *Motor–Basal* metabolism unit, which records the basal metabolic rate by measuring the time needed for consumption of a predetermined quantity of oxygen, which is automatically corrected by the unit for barometric and temperature changes, will be exhibited. Also exhibited will be the *Cardiotron*, a portable direct-recording electrocardiograph which affords new convenience in cardiology.

63 Paravox Hearing Aids, Cleveland

The Paravox Hearing Aids, with the exclusive, internal-type, plastic chassis, will be demonstrated and explained. As a part of the exhibit an illuminated display features all the models, showing, step by step, the production of the *Paravox*. Included in this display is the printed circuit, and how it is incorporated in the *Paravox*. Ease of servicing is an important part of the Paravox demonstration. The *Veri-small Paravox*, unusually small and compact, is a featured part of the display.

49 Parke, Davis and Co., Detroit

Trained representatives will be on hand to discuss new and old products. Featured will be such outstanding specialties as *Benadryl*, vitamins, *Adrenalin*, and *Thrombin Topical*. Also, the most recent types of biologicals, including other therapeutic agents of chemotherapeutic interest, will be displayed.

Booth COMPANY AND PRODUCTS

12 H. E. Pengelly X-Ray Company, Milwaukee

We carry a complete line of x-ray apparatus extending from mobile units, complete radiographic units, and deep therapy equipment, plus all accessories required for the x-ray department.

48 Pet Milk Company, St. Louis

Specially trained representatives will be in attendance to discuss the use of *Pet Milk* in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

3 Philip Morris & Co., Ltd., New York

S–36 Photoart Visual Service, Milwaukee

This exhibit will consist of an attractive display of latest motion picture camera and projector, slide and filmstrip equipment, and other photographic material of interest to the medical profession. Complete display of items necessary for proper visual presentation of teaching and research aids. Motion picture and slide equipment available for projection purposes within the booth.

55 Physicians and Hospitals Supply Co., Minneapolis

You are cordially invited to visit booth 55. Our representatives, Don Grinnell and John Hanke, will welcome an opportunity to show you the new *Console Model Microtherm,* the new Model ERA Beck–Lee electrocardiograph and many other new and interesting items.

76 Pitman–Moore Company, Indianapolis

The Pitman–Moore display will feature several new advancements in medication, including the new ultraviolet irradiation-killed rabies vaccine; *Magmoid* Sulco, a creamy liquid mixture of sulfonamides designed to reduce the danger of crystalluria; and *Tablets Rutol,* a new hypotensive with *Rutin,* for the purpose of reducing the dangers of capillary fragility. Medical service representatives from this region will be on hand to greet their friends in the profession.

S–6 Professional Budget Plan, Madison, Wis.

Efficient office organization, effective control of accounts, and ethical practice-building ideas key the success of the *personalized* Professional Budget Plan. Collection of cash and time payments (old accounts, too), a smoothly functioning appointment system, and simplified bookkeeping are but three of the major points covered. See the special counsellor at the booth to learn how this modern business system fits your practice.

43 Roemer Drug Company, Milwaukee

Physicians' complete office equipment, drugs, hospital and laboratory supplies will be displayed.

52 Sandoz Chemical Works, Inc., New York

Among recently released Sandoz medicinal specialties are *Mesantoin* (methyl-phenyl-ethyl-hydantoin), antiepileptic for the control or reduction in the frequency of epileptic seizures; *Dihydroergotamine 'Sandoz'* (D.H.E.–45), the improved non-narcotic relief for migraine, and *Glysennid* for constipation. Also displayed are *Cedilanid,* stable preparation of lanatoside C, a crystalline glycoside from Digitalis lanata, not present in purpurea; *Ipesandrine Syrup* for the relief of cough and bronchial disorders, and other well known Sandoz products such as *Gynergen, Digilanid, Bellafoline, Belladenal, Bellergal, Calcibronat, Scillaren, Strophosid, Calglucon,* and *Neo-Calglucon.*

57 W. B. Saunders Company, Philadelphia

Mr. Paul Graebner will exhibit a full line of Saunders medical books, including Hyman's "Integrated Practice of Medicine," Bockus' "Gastro-enterology," Kinsey's "Sexual Behavior in the Human Male," Sollmann's "Pharmacology," Beckman's "Treatment," Todd & Sanford's "Clinical Diagnosis by Laboratory Methods," Christopher's "Minor Surgery," Dowling's "Acute Bacterial Diseases," Noyes' "Clinical Psychiatry," A.M.A. Interns' Manual, Brams' "Treatment of Heart Disease," Willius & Dry's "History of Heart and Circulation," Thorner's "Psychiatry in General Practice," 1948 Mayo Clinic Volume, Long's "Sulfonamide and Antibiotic Therapy," Bastedo's "Pharmacology, Therapeutics and Prescription Writing," and many others.

9 Schering Corporation, Bloomfield, N.J.

Among the new pharmaceutical and hormone preparations developed in the Schering research laboratories, *Micropellets Progynon* will be featured. This new potent form of the female sex hormone, alpha estradiol, provides maximum results at minimum cost to the patient. *Combisul* and *Combisul Liquid,* the triple sulfonamide combinations which eliminate the dangers of sulfonamide renal damage will also be presented. *Trimeton,* the outstanding antihistaminic will highlight the exhibit. Schering representatives will be happy to answer your inquiries concerning Schering's new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

10 G. D. Searle & Company, Chicago

Features of the Searle exhibit will be *Ruphyllin,* for abnormal capillary fragility; *Hydryllin,* new and effective antihistaminic, as well as such time-proven products as *Searle Aminophyllin* in all dosage forms, *Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine,* and *Pavatrine with Phenobarbital.*

18 Sharpe & Dohme, Inc., Philadelphia

Items on exhibit at our booth will include a new dosage form of *Delvinal Sodium Vinbarbital* for the production of obstetric amnesia and analgesia. New antibiotic preparations, including *Tyrothricin* along with *Sulfathalidine* and *Sulfasuxidine,* intestinal bacteriostatic agents are also being featured.

53 Smith–Dorsey Company, Lincoln, Neb.

Aminophyllin Suppositories for symptomatic relief of asthmatic paroxysms will be featured at the Dorsey exhibit. Estrogenic hormones,

Booth COMPANY AND PRODUCTS

Liver, Aminophyllin and other injectable materials will also be displayed. Dorsey representatives will be happy to discuss the use of these products with physicians in attendance, and we invite you to make our booth your headquarters during the meeting.

5 Smith, Kline and French Laboratories, Philadelphia

Dexedrine Sulfate (dextro-amphetamine sulfate, S.K.F.): *Dexedrine* therapy, now established as the treatment of choice in overweight, spares the patient the discouragement and irritability which ordinarily accompany adherence to reducing regimens. Because it successfully curbs appetite, *Dexedrine* makes it easy for the overweight patient to stop overeating. Thus it reduces weight safely, without the use (and risk) of such drugs as thyroid.

4 Spencer, Inc., New Haven, Conn.

You are cordially invited to visit our exhibit of Spencer individually designed supports for abdomen, back, and breasts. The *Spencerflex*, a light, comfortable, masculine-looking support for men, will be featured. This support improves posture, increases efficiency, and helps prevent hernia. It is especially suited for postoperative wear. Another support to be shown is the *Spencer Spinal Support*, designed to aid in the treatment of spinal curvatures and back injuries and for wear following spinal operations. The *Spencer Breast Form*, which conceals disfigurement and restores normal figure lines for the mastectomy patient, will also be shown.

54 E. R. Squibb and Sons, New York

Presenting *Liafon* (Squibb Desiccated liver, ferrous sulfate exsiccated, ascorbic acid and folic acid) and *Crysticillin*, the new procaine penicillin G for aqueous injection.

41 U. S. Standard Products Co., Woodworth, Wis.

We extend a welcome to you to visit our booth number 41, where our Wisconsin representatives and technical executives from our laboratories will be on hand to greet you.

7 U. S. Vitamin Corporation, New York City

Enlarged color photographs of common signs of nutritional deficiency, including Bitot's spots, follicular hyperkeratosis, beriberi heart, pitted edema, glossitis, cheilosis, pellagrous dermatitis, gingivitis, rickets, pyridoxine anemia, and others. Also complimentary copies of illustrated brochure, "Diagnosing Vitamin Deficiencies," "Vitamin Manual for Physicians," and other educational material.

19 Varick Pharmacal Company, New York

Varick Pharmacal Company, the manufacturers of *Digitaline Nativelle* are proud to present an interesting and informative exhibit on heart disease. Featured will be *Digitaline Nativelle*, crystalline digitoxin, the chief cardioactive glycoside of digitalis purpurea. Samples and literature will be available.

2 White Laboratories, Inc., Newark, N. J.

White's *Dienestrol Tablets* and *Dienestrol Suspension* (Council accepted)—a new orally effective synthetic estrogen is featured. Complete information and literature are available regarding the advantages of *Dienestrol's* high biologic activity, excellent patient-tolerance, and economy.

Other products of White Laboratories, Inc. are on display, and White's medical service representatives in attendance will be pleased to supply any further information requested.

36 Winthrop–Stearns Inc., New York
62

We invite you to visit our booth where representatives will be on hand to discuss the latest therapeutic contributions made by our firm. Featured will be *Creamalin*, nonalkaline, nonabsorbable antacid; *Demerol*, powerful analgesic, spasmolytic and sedative; and *Neo-Synephrine*, well tolerated, prolonged decongestive. A supplementary display will be housed in booth 62.

S–3 Wright's Incorporated, Milwaukee

Founded in 1858 to serve a useful purpose throughout Wisconsin to the medical profession. We invite your attendance at our exhibit to see the many fine products we have to offer.

59 Zimmer Manufacturing Company, Warsaw, Ind.

A complete line of fracture equipment will be presented, and we invite you to visit with us and inspect our products. Mr. C. B. Robbins is back on the territory and will be in charge of exhibit.

NOMINATIONS FOR SCHOLARS IN MEDICAL SCIENCE

Medical schools in the United States and Canada have been invited by the John and Mary R. Markle Foundation to make nominations for the second group of scholars in medical science on or before December 1, 1948. Each school, through the dean, may nominate one candidate. No nominations from individuals will be considered.

The program is designed to aid promising young men and women planning careers in academic medicine, who have not yet made their reputations. Grants of $25,000, payable at the rate of $5,000 annually, will be made to the schools over a five-year period for the support of each scholar finally selected, his research, or both.

The number of scholars to be appointed in 1949 has not yet been determined. Sixteen were chosen in 1948.

House of Delegates—1948

PLACE OF MEETING:

Banquet Room, Fifth Floor, Hotel Schroeder.

SCHEDULE OF MEETINGS:

Sunday, October 3; 1:30 p. m.

Monday, October 4; 6:00 p. m.

Tuesday, October 5; 9:00 a. m.

MEETINGS OF REFERENCE COMMITTEES:

Organizational Meetings: Sunday, 7:00 p. m.

Open Meetings: Monday, 9:00 a. m.

Committee on Credentials: At Registration Table outside of Banquet Room (fifteen minutes before each session of the House).

Committee on Reports of Officers: Room C, Fifth Floor, Hotel Schroeder.

Committee on Resolutions and Amendments to the Constitution and By-Laws: Banquet Room, Fifth Floor, Hotel Schroeder.

Committee on Reports of Standing Committees: Room B, Fifth Floor, Hotel Schroeder.

Committee on Nominations: Committee Room, Fifth Floor, Hotel Schroeder (directly north of Banquet Room). 9:00–10:00 open meeting; 10:00 on, executive session.

Society	*Delegates*	*Alternate*
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	W. E. Bargholtz, Ashland
Barron–Washburn–Sawyer–Burnett	S. O. Lund, Cumberland	O. E. Rydell, Rice Lake
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	W. P. Tippet, Green Bay
	A. J. McCarey, Green Bay	W. A. Killins, Green Bay
Calumet	A. C. Engel, New Holstein	E. W. Humke, Chilton
Chippewa	S. E. Williams, Chippewa Falls	J. J. Sazama, Chippewa Falls
Clark	M. V. Overman, Neillsville	H. H. Christofferson, Colby
Columbia–Marquette–Adams	R. B. Dryer, Poynette	J. H. Houghton, Wisconsin Dells
Crawford	E. H. Lechtenberg, Prairie du Chien	T. F. Farrell, Prairie du Chien
Dane	T. A. Leonard, Madison	A. T. Smedal, Stoughton
	C. G. Reznicheck, Madison	J. P. Malec, Madison
	L. R. Cole, Madison	J. H. Robbins, Madison
	J. S. Supernaw, Madison	B. I. Brindley, Madison
	L. V. Sprague, Madison	J. A. Hurlbut, Madison
Dodge	M. M. Temkin, Beaver Dam	A. B. Kores, Beaver Dam
Douglas	Charles W. Giesen, Superior	Conrad Giesen, Superior
Eau Claire–Dunn–Pepin	W. O. Paulson, Eau Claire	C. M. Ihle, Eau Claire
Fond du Lac	D. J. Twohig, Fond du Lac	D. N. Walters, Fond du Lac
Forest	G. E. Carroll, Laona	O. S. Tenley, Wabeno
Grant	J. D. Glynn, Lancaster	M. W. Randall, Blue River
Green	M. W. Stuessy, Brodhead	F. J. Bongiorno, Albany
Green Lake–Waushara	L. J. Seward, Berlin	Mildred Stone, Berlin
Iowa	W. P. Hamilton, Dodgeville	E. J. Hohler, Mineral Point
Jefferson	A. C. Nickels, Watertown	C. J. Garding, Jefferson
Juneau	C. A. Vogel, Elroy	J. S. Hess, Mauston
Kenosha	W. C. Stewart, Kenosha	G. C. Schulte, Kenosha
La Crosse	C. F. Midelfort, La Crosse	P. V. Hulick, La Crosse
Lafayette	N. A. McGreane, Darlington	Mary P. Gratiot, Shullsburg
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	K. A. Morris, Merrill
Manitowoc	E. C. Cary, Reedsville	E. W. Huth, Valders
Marathon	M. L. Jones, Wausau	A. H. Stahmer, Wausau
Marinette–Florence	H. W. Haasl, Peshtigo	K. G. Pinegar, Marinette
Milwaukee	H. H. Huber	D. V. Elconin
	N. J. Wegmann	
	E. L. Bernhart	J. A. Enright
	R. E. Galasinski	W. T. Casper
	T. J. Aylward	A. J. Baumann
	D. F. Pierce, Hales Corners	S. W. Hollenbeck
	Aaron Yaffe	S. K. Pollack
	H. W. Hefke	H. W. Pohle
	C. M. Echols	J. G. Garland
		L. J. Schneeberger
	J. V. Herzog	J. D. Charles
	M. Q. Howard	L. J. Schwade
	F. E. Drew	Joseph Shaiken
	Norbert Enzer	A. J. Baumann
		W. J. Houghton
	J. W. Fons	E. R. Daniels
	Forrester Raine	H. N. Dricken
	M. C. Borman	J. P. Conway

Society	*Delegates*	*Alternate*
Monroe	J. S. Allen, Norwalk	G. C. Devine, Ontario
Oconto	R. J. Goggins, Oconto Falls	A. F. Slaney, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	R. V. Landis, Appleton
Pierce–St. Croix	C. E. McJilton, River Falls	O. H. Epley, New Richmond
Polk	L. O. Simenstad, Osceola	V. C. Kremser, Amery
Portage	E. E. Kidder, Stevens Point	W. C. Sheehan, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	L. E. Nystrum, Medford
Racine	C. O. Schaefer, Racine	G. N. Gillett, Racine
	G. J. Schulz, Union Grove	E. J. Schneller, Racine
Richland	Geo. Parke, Sr., Viola	Geo. Parke, Jr., Richland Center
Rock	H. E. Kasten, Beloit	W. T. Clark, Janesville
	W. A. Munn, Janesville	R. A. Thayer, Beloit
Rusk	L. M. Lundmark, Ladysmith	Woodruff Smith, Ladysmith
Sauk	Roger Cahoon, Baraboo	J. F. Moon, Baraboo
Shawano	A. A. Cantwell, Shawano	E. E. McCandless, Wittenberg
Sheboygan	P. B. Mason, Sheboygan	J. A. Russell, Random Lake
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	R. S. Hirsch, Viroqua	F. F. Gollin, La Farge
Walworth	E. D. Sorenson, Elkhorn	R. A. Mullen, Burlington
Washington–Ozaukee	Arnold Barr, Pt. Washington	T. D. Elbe, Thiensville
Waukesha	F. J. Woodhead, Waukesha	E. C. Van Valin, Sussex
Waupaca	A. M. Christofferson, Waupaca	F. J. Pfeifer, New London
Winnebago	B. J. Hughes, Winnebago	G. R. Anderson, Neenah
Wood	R. E. Garrison, Wis. Rapids	F. X. Pomainville, Wis. Rapids
Section on Internal Medicine	F. L. Weston, Madison	F. W. Madison, Milwaukee
Section on Ophthalmology and Otolaryngology	L. A. Copps, Marshfield	K. W. Covell, Racine
Section on Orthopedics	R. P. Montgomery, Milwaukee	L. D. Smith, Milwaukee
Section on Radiology	L. V. Littig, Madison	W. T. Clark, Janesville

The Annual Dinner

HOTEL SCHROEDER **TUESDAY, OCTOBER 5**

5:30 p.m.: **President's Reception—Banquet Room**

All physicians and wives invited to this preprandial hour to meet the honored guests and distinguished speaker.

6:30 p.m.: **Dinner—Crystal Ballroom**

Speaker: H. C. Urey, Ph. D., D. Sc., University of Chicago.
"Social Implications of Atomic Energy"

Citation of new members of "50 Year Club"

HAROLD C. UREY, Ph. D.

Only 450 tickets for this dinner can be sold. You are urged to make your reservations in advance if possible. If any tickets are left at the time of registration they may be purchased at the Registration Desk in the Milwaukee Auditorium on Monday, October 4 and Tuesday, October 5.

★ ★ ★

GOLF TOURNAMENT OCTOBER 6: The Wisconsin Medical Golf Association announces its annual tournament, to be held at the Merrill Hills Country Club, Waukesha, October 6. Tournament play will start at noon, and a banquet will be held at 6:30 p.m. Full information and reservations for the banquet can be secured by writing G. R. Love, M. D., Summit Hospital, Oconomowoc.

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STATE MEDICAL SOCIETY OF WISCONSIN

W. D. STOVALL
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President-Elect

GUNNAR GUNDERSEN
La Crosse
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Shawano
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Madison
Treasurer

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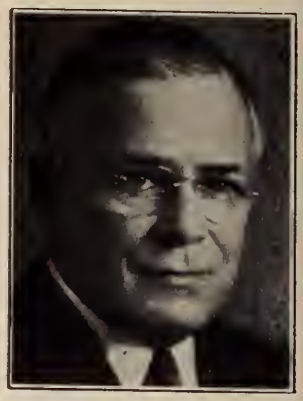
La Crosse
Councilor, 7th District

J. M. BELL
Peshtigo
Councilor, 8th District

H. H. CHRISTOFFERSON
Colby
Councilor, 9th District



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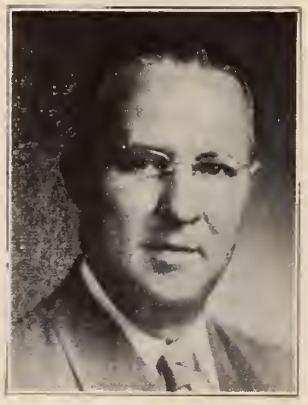
Frederic
Councilor, 10th District

V. E. EKBLAD
Superior
Councilor, 11th District

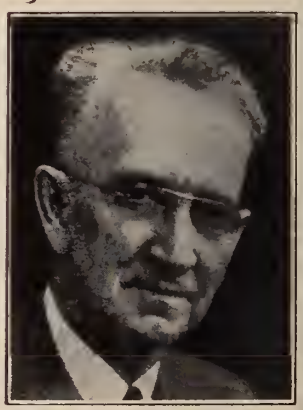
D. H. WITTE
Milwaukee
Councilor, 12th District

R. E. FITZGERALD
Milwaukee
Councilor, 12th District



J. W. TRUITT
Milwaukee
Councilor, 12th District

J. D. LEAHY
Park Falls
Councilor, 13th District



C. A. DAWSON
River Falls
Past-President

The
MEDICAL FORUM

The Wisconsin Medical Journal — September, 1948

COUNTY SOCIETIES ASKED TO ASSURE NIGHT CALLS

START HOUSE-TO-HOUSE DRIVE FOR CO-OP HOSPITAL IN POLK COUNTY

Enlist Aid of National Cooperative Leaders in New Campaign

Frederic, Wis., Aug. 25.—An all-out campaign starting Sept. 1 to establish a Polk county cooperative hospital at Milltown has been outlined by Paul Bosley, director of the Polk–Burnett Cooperative Health Association.

He said the drive would start "at once" in some townships and preliminary surveys have "shown strong support" for the hospital.

The main fall drive, he said, will cover "farm by farm an family by family the entire hospital area which comprises approximately 14 towns and several villages." Community leaders have been appointed and a call for field workers has been issued.

"No effort will be spared to make the campaign a success both educationally and financially," stated officers of the cooperative.

New Directors

Another cooperative director announced that two men who have been successful in organizing cooperative hospitals in the state of Washington have been added to the staff of the Health Center Services Committee, St. Paul, which aids the Polk county cooperative group. They are Dr. H. M. Hardwicke, medical director of the Cooperative Health Federation of America, and R. M. Cole, executive director. Both men are now active in the Polk county area.

The Polk county hospital association is being aided by Group Health Association, St. Paul; Midland Cooperative Wholesale, Minneapolis; Central Cooperative Wholesale, Superior; Arrowhead Health Center, Inc., Duluth; Cooperative Health Assn., Inc., and Community Health Center, Inc., and the Polk–Burnett Cooperative.

Dr. Ira F. Thompson.

THOMPSON AND GAVIN HEAD HEALTH BOARD

Relax Placarding Rules

Milwaukee, Aug. 1.—Dr. Ira F. Thompson, Beloit, was elected president of the state board of health and Dr. Stephen E. Gavin, Fond du Lac, vice-president, at the July-August meeting of the board held at Statesan and Milwaukee.

Dr. Thompson succeeds Dr. Gundersen, La Crosse, recently elected to the board of trustees of the American Medical Association. Dr. Gavin succeeds Dr. Thompson.

Several changes in the state's communicable disease control rules were adopted by the board. The new regulations, adopted after consultation with the State Medical Society and the full-time health officers of the state, are not as stringent as those formerly in effect.

The major change was a reduction of the number of diseases which require placarding. Chicken pox, measles, German measles, mumps and whooping cough no longer are required to be placarded.

Urged to Inform Public of Plans to Handle Night-Emergency Cases

Madison, Aug. 23.—All county medical societies have been asked to take "immediate steps to assure the public that it will be able to secure medical attention at night or in emergencies," the State Medical Society of Wisconsin announced in a news letter to all county society officers.

The Council on Medical Service and Public Relations with approval of the General Council has notified county societies that this might be accomplished by one of the following methods:

1. Set up a physician's telephone service, such as operates in Milwaukee on a 24-hour basis, that will help locate a particular doctor for a patient, send a doctor in an emergency, provide the names of several doctors for those who have no family physician, and act as a general information center for obtaining medical attention.

2. Make arrangements with a hospital, police station or sheriff's office to handle emergency calls through a panel of physicians. Under this plan, the doctors would serve in rotation, agreeing to accept night calls and emergency cases perhaps one night a week or whatever number is required.

3. Establish a 24-hour switchboard service with the local hospital to handle night and emergency calls. This has been done at

(Continued on page 4)

ON THE INSIDE

Subject	Page
Blue Cross	7
Blue Shield	3
Hearing Program	6
Hospitals	5
Prepayment Plans	7
Public Relations	8
Wisconsin Plan	2

"NEW" WISCONSIN PLAN COVERS 3,500 EMPLOYEES OF MADISON PACKING PLANT

Workers Get $14,000 Benefits in Two Months; Pays Direct to Doctors–Hospitals

Madison, Aug. 30.—More than 3,500 employees of Oscar Mayer & Co., one of the state's largest meat packing concerns, are now covered by the Wisconsin Plan of prepaid surgical, obstetric and hospital care, reports Oscar G. Mayer, president.

When the plan was installed on June 1, 1948, through the cooperation of the company and the plant employees' union, Oscar Mayer & Co. became one of the first major concerns to adopt the "new" Wisconsin Plan. The new plan has a revised schedule of benefits to meet new specifications of coverage.

During the months of June, July and August more than $14,000 was paid out in surgical and hospital benefits to employees covered by the Wisconsin Plan, according to Stanton T. Stavrum, personnel manager at Oscar Mayer & Co.

Share Premium Cost

Describing how the plan works at his plant, Stavrum explained that the premiums are paid on a "cooperative basis with each employee paying a portion of the cost and the company assuming the remainder." The plan is available to all Oscar Mayer employees in Wisconsin, but none is required to subscribe to the group.

At present 2,973 employees have single coverage and 1,962 have family coverage under the plan, Stavrum said. All matters relating to the Wisconsin Plan are handled by Miss Marian R. Brandt, insurance secretary for Oscar Mayer & Co., he said.

Madison hospitals have Wisconsin Plan claim blanks and whenever an Oscar Mayer employee covered by the plan leaves the hospital the completed claim blank goes directly to Miss Brandt. She audits the claims and writes the checks according to the Wisconsin Plan schedule of benefits.

Direct Payment

"All benefit payments go directly to the physician or hospital involved since an assignment form is completed by all employees,"

Miss Marian Brandt, insurance secretary, handles all Wisconsin Plan claims for Oscar Mayer & Co.

Miss Brandt explained. "This satisfies the employees as well as the doctors and the hospitals."

Whenever a family physician renders surgical treatment in his office for which Wisconsin Plan benefits are payable the employee obtains a claim blank from the Oscar Mayer personnel office, Miss Brandt said. The physician completes the form and returns it to the office for routine payment.

"We have received excellent cooperation from the local physicians and hospitals in the operation of our Wisconsin Plan program," Miss Brandt declared.

The Wisconsin Plan is only part of the social program worked out between the company and the employee's union at Oscar Mayer & Co. Other benefits available to employees are a health and accident policy paying weekly benefits for away-from-the-plant disabilities, a life insurance program and a sick leave system.

Personnel director Stanton T. Stavrum goes over a Wisconsin Plan claim with Miss Brandt. More than 3,500 employees of Oscar Mayer & Co. are covered by the plan.

San Diego Puts Mental Quacks Out of Business

San Diego, Calif., Aug. 21.—Climaxing a two months' campaign by the *San Diego Journal* to put "mental healer" quacks out of business, the city council adopted an ordinance strictly regulating licensing of psychologists. San Diego thus became one of the first cities in the nation with such legislation.

The existence of a $1,000,000-a-year racket in San Diego among fake mental doctors had been revealed by a *Journal* reporter. In a series of articles, he demonstrated how simple it was for anyone, regardless of qualifications, to obtain a municipal license and open an office to prey on persons in need of genuine psychiatric treatment. He personally paid a small fee at the San Diego City Hall, and was given a license as a practicing psychologist—no questions asked.

As a result of the series, the city council adopted an ordinance that provides that applicants must have an established reputation for honesty and integrity, sufficient professional education and training to practice in the field. A five-man board, including three members of the American Psychological Association, will be appointed by the major to pass on applicants.

Report Shows 18 Million in Hospitals Last Year

Government Hospitals Have 72% of Beds; Admit Only 26% of Patients

Chicago, Aug. 10.—Almost 18 million Americans were admitted into the nation's 6,173 hospitals last year, according to the 1948 American Hospital Directory compiled by the American Hospital Association. This means that one out of every eight persons received hospital care.

In addition, 40 million hospital visits were made by outpatients, those needing special tests or treatments without bed care. The average cost of caring for a patient for one day in a general hospital rose from $9.39 to $11.09 in the year 1946–1947, according to the Directory. Yet the average income from patients was $9.71, leaving a daily deficit of $1.38 per patient to be made up through voluntary contributions or gifts from the public.

The Directory states that 79 fulltime employees served every 100 patients in all types of hospitals, while general hospitals had about 151 employees for every 100 patients.

The Council on Medical Education and Hospitals of the AMA also released its annual hospital report showing that the government hospitals with 72% of the bed capacity reported 4,200,000 admissions or 26.5% of all patients admitted in 1947. The non-government hospitals with 27% of the beds had 11,600,000 admissions, or 73%.

Name Medical Advisors to Board of Vocational and Adult Education

Madison, July 30.—The appointment of the members of the state professional medical advisory committee to the Wisconsin State Board of Vocational and Adult Education has been announced by C. L. Greiber, state director.

Members are Dr. Charles Fidler, Milwaukee; Miss Janet Jennings, Madison; Dr. J. S. Supernaw, Madison; Dr. G. F. Wakefield, West Salem; Dr. H. M. Coon, Madison; Dr. H. L. Greene, Madison; Dr. T. J. Howard, Milwaukee; Dr. R. M. Kurten, Racine; Dr. Lyman A. Copps, Marshfield; Dr. H. J. Heeb, Milwaukee; Dr. C. N. Neupert; and Dr. H. H. Reese, Madison, and Miss Marjorie Taylor, Milwaukee.

Ex officio members include Dr. W. D. Stovall and Mr. C. H. Crownhart, Madison; W. F. Faulkes, A. E. Towne and Dr. A. W. Bryan of Madison.

PAYMENT OF DOCTORS SPEEDED UP IN WPS–BLUE SHIELD PLAN: WEBER

Will Improve More If Doctors Send Reports Without Delay

Madison, Aug. 28.—Physicians are being paid for their services rendered under the Blue Shield plan (Wisconsin Physicians Service) faster and with less difficulty than ever before, states Ralph F. Weber, director of Wisconsin Physicians Service.

He explained the procedure by which this is accomplished as follows:

The physician determines that a patient needs surgery or some other procedure covered under the plan. The patient is sent to the hospital where he receives treatment provided under the joint Blue Cross—Blue Shield contract.

The hospital prepares an admission form, sending multiple copies to the Blue Cross office in Milwaukee, one copy of which goes immediately to the Blue Shield (WPS) office.

When the WPS office verifies the fact that the patient is intitled to Blue Shield benefits, a Physicians' Service Report is sent to the attending physician. It takes only two to four days for the doctor to receive this Report blank after the patient is admitted.

Mr. Weber emphasized that there is no need for the doctor to contact WPS unless he has not received the report form on the hospital admission after a lapse of several days. Likewise, there is no need for the doctor to tell a patient to request that the report form be sent to him or the doctor.

The Physician's Service Report form has been simplified and much of the information is inserted at the WPS office before it goes to the doctor. The physician is asked only to fill in the days of hospitalization, whether surgery, medical, maternity, diagnostic x-ray or anesthesia were performed, type of care performed, diagnosis and the doctor's signature.

Vouchers for payment of the physician can be prepared quickly if the report is returned by the physician without delay, Weber said.

Annual Cancer Drive Nets $194,265 for Wisconsin

Madison, Sept. 1.—A total of $194,265.81 has been contributed to the Wisconsin Division of the American Cancer Society as a result of its annual drive for cancer funds, it was announced by Mr. R. O. McLean, executive secretary of the division.

Forty-four counties had surpassed their 1948 goals as early as July 31 with another month to go in the campaign. At that time, $134,000 had been received through the Field Army and $41,000 through industrial sources.

YOU ARE 100 YEARS OLD BUT ONCE

Wisconsin is making the most of its first 100 years of Statehood—giving recognition to its sons and daughters, its industries and professions—all of the things that have made Wisconsin a great State.

The practice of medicine in Wisconsin has more than kept pace with the rest of the world. The medical profession, together with the economic standards of Wisconsin, has made Wisconsin a healthy place to live.

Our business brings us in close contact with the medical practitioners of Wisconsin, and to this profession may we convey our thanks for your part in developing this great State during its first 100 years.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

Doctor's Complaint

A Letter in the London Times

To the Editor: During the last seven days, in addition to my ordinary daily work as a country doctor, which means long hours of motoring, visits and surgery attendances, I have been called upon to issue medical certificates for (1) vacuum flasks, (2) corsets, (3) coal, (4) brassières, (5) hot-water bottles, (6) elastic stockings, (7) outside shoes, (8) milk, (9) eggs, (10) clothing coupons for expectant mothers, (11) overseas travel, (12) successful vaccination and inoculation, (13) children's family allowance, (14) glucose, (15) Horlick's, (16) brandy, (17) whisky, (18) petrol and (19) paraffin. Further to this, all my "panel" patients when sick demand a duplicate certificate for their employer if they are employed in any government or municipal work, otherwise they lose some of their sick benefit.

My real work — treating the sick — is becoming of secondary importance.

Yours faithfully,
R.O.T., M.D., Swaffham, Norfolk, England

—Nassau Medical News

Shawano Newspaper Favors Continuation of Free Enterprise System in American Medicine

NIGHT CALLS—

(Continued from page 1)

River Falls where the clinic constitutes all the local physicians.

4. Each physician should inform his patients as to how he may be reached in an emergency, or whom the patient should call in event he cannot be reached at any time of day or night. This is for the convenience of the doctor as well as the patient.

5. Each doctor, group of doctors or county medical society shall inform the public that the profession has taken steps to provide this service and explain how it is to be operated.

The Council requests that all county societies, groups of physicians, or physicians and hospitals having any arrangements for night or emergency calls already in operation take steps to explain their existence and operation to the public through the newspapers and radio stations.

The State Medical Society will make every effort to inform the public of its responsibilities in the matter of night calls, but in the last analysis physicians and county medical societies are asked to demonstrate their willingness and ability to solve the problem wherever it exists and to prevent it from arising in any area.

A *Shawano Evening Leader* editorial of June 12, 1948, presents a strong case for the preservation of the free enterprise system of medical care.

"Competing for Your Favor"

There are many strong arguments against compulsory tax supported government health plans. One which isn't used as much as it deserves is that it would eventually establish a government monopoly in the field.

A short time ago a subscriber to one of the voluntary plans spent a short period in a hospital. The bill, which the plan paid, totaled much more than his dues for a year. After he got out he received a courteously phrased card, telling him that the plan had met his bill of some $70, offering the hope that the service was entirely satisfactory, and asking that he tell his friends about it. In the same mail there was an advertisement from a competing plan of a similar nature, describing the service and the benefits it offered.

This is a typical demonstration of the free competitive system. If a man doesn't like one prepaid medical plan, he can subscribe to another or to none at all—just as if he doesn't like one brand of goods he can buy a competitive brand or skip the purchase entirely. The service has to please the customers or the concern doesn't last.

The American Academy of Pediatrics, through its state chairman, Dr. H. Kent Tenney, Jr., Madison, has announced that the academy has been given a three-year, $50,000 grant from the National Foundation for Infantile Paralysis. It will be used to support the Academy's program for improvement of child health started by nation-wide surveys.

* * *

The Socialist Platform has been analyzed by Capital Times Editor Evjue—his comment on health follows:

"The plank on insurance calls for an extension of state insurance into fields of health and automobile accidents. We agree that health should be regarded as a public province, just as education is. The need for state automobile insurance is apparent . . . "

* * *

The state board of health has been allocated $75,000 of federal funds as a grant-in-aid for mental health activities under the National Mental Health Act. The amount was allocated on the basis of two federal dollars for every state dollar.

* * *

Ten billion dollars have been paid into the Social Security Administration in 11 years and 850 million dollars collected in interest. Benefits paid total 1½ billion dollars and administrative costs $250,000,000. The AMA asks: "Where is the rest of it?"

* * *

Two Wisconsin men have been appointed to the 12-member National Advisory Heart Council which will advise the Surgeon General on all phases in the development of the National Heart Institute. They are Dr. C. A. Elvehjem of the University of Wisconsin and Ernest Mahler of Neenah, executive vice president of the Kimberly-Clark Corp.

"IS VET PROGRAM NUDGING US INTO SOCIAL MEDICINE?" WRITER ASKS

OUT OF REASON: BRONS

Chicago, July 20.—The subject of whether America may be backing into socialized medicine through the government program of care for veterans is going to be increasingly difficult to keep under cover in the next few years, states W. J. Brons, author of "The Round Table" in the Chicago *Journal of Commerce.*

"More than 80 per cent of the beds in veteran's hospitals in this area (Chicago) are occupied by veterans whose disabilities can't be traced to their service in the armed forces," he said.

As the law now stands, Mr. Brons wrote, a veteran may go to a government hospital at any time for medical treatment or surgery. He is required to make a statement that he can't afford private medical care. But this requirement has become largely a matter of form and the signer rarely is questioned as to his financial ability.

Demand Is High

"Demand for free service is so great that the veterans' medical program alone is costing the government currently some $400,000,000 a year. What it will cost when the majority of World War II vets arrive at the age when illness is to be expected can only be guessed. If we extend the same privileges to the new draftees, the total cost a decade hence could easily be in excess of two billions a year."

Free Service Unreasonable

Few Americans begrudge the nearly 10 billion dollars spent on veterans since 1944, Mr. Brons wrote, especially when the premise all along has been that after the veteran is readjusted he will be a self-sufficient citizen, or at least as much so as the rest of us in this day and age.

"On the other hand," Mr. Brons said, "free medical service for life to millions of men who left the armed forces in good physical condition is stretching government's responsibility out of all semblance to reason."

VA SHOWS EXPANSION

Washington, D. C., Aug. 14.—A fact sheet recently published by the Veterans Administration describes the scope and functions of the VA in the field of medicine and surgery. Part of this report follows:

"One of the VA's most important functions is to provide medical care for disabled veterans, a nation-wide network of modern, well-equipped and properly staffed hospitals, together with numerous out-patient clinics both for general medical purposes and for mental hygiene, officer eligible veterans medical care on a par or above that generally available.

"One hundred and twenty-six hospitals (including a number of temporary structures taken over from the Armed Services at the end of World War II) are being utilized to hospitalize veterans. In addition, there are 144 out-patient clinics in VA regional and other VA offices, 56 mental hygiene clinics operated by VA and 54 under contract.

"Completion of 89 new hospitals in the present construction program will provide an additional 52,000 beds for the ill and disabled. Two new hospitals have been completed in recent months.

"The medical staff includes near 15,000 full-time doctors, dentists and nurses. In addition, VA is using the services of approximately 2,000 residents, 2,000 part-time physicians, 475 consultants and 310 attending physicians. Thousands of civilian doctors working on a fee basis also are available to eligible veterans in almost every community of the nation.

Seven Hospital Projects Named for Federal Aid

Earmark 2nd Year Allotment

Madison, Aug. 4.—State approval of seven more general hospital projects under the five-year Hill–Burton hospital survey and construction program has been announced by the state board of health.

Subject to approval by the federal public health service, Wisconsin's second-year allotment of $973,440 in federal grants for hospitals of the general type has been earmarked as follows:

Locality	*No. of Beds*	*Federal Funds*
Tomah	50	$210,000
Menomonie	32	130,000
Platteville	30	130,000
Dodgeville	43	238,800
Osceola	10	30,000
Burlington	26	132,000
Boscobel	40	100,517

Platteville gained its place in the program as a substitute for Darlington, whose entry will be postponed a year to permit settlement of litigation involving a technicality.

60 Per Cent Allotted

In each case the funds mentioned represent one-third of the construction costs. The remaining two-thirds, plus cost of the building site, is borne by the community concerned.

The $973,440 in federal funds which became available for allotment on July 1 represents only 60 per cent of Wisconsin's second-year share in the five-year plan to make modern hospital facilities available throughout the state.

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Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions
References furnished on request.

Doctors Cooperate in Wisconsin Hearing Program

TEST 7,000 CHILDREN IN TWO COUNTIES; FIND 8% HAVE HEARING LOSS

It is generally conceded that most hearing defects of adults are fixed and to a large extent irreversible. But the majority of hearing defects of school children can be remedied, declares Dr. W. E. Grove, Milwaukee, chairman of the State Medical Society Committee on Hearing Defects.

While prevention is the major goal, the immediate results are in the field of correction and amelioration. For three years the Committee on Hearing Defects of the State Medical Society (now consisting of Drs. Grove: T. L. Tolan, Milwaukee, and W. B. Dimond, Madison) has cooperated with the State Department of Public Instruction, the State Board of Health, the University of Wisconsin and local community agencies and individuals to activate a hearing program in several demonstration areas in the state.

The program got under way when Mr. Frank Powell of the Bureau for Handicapped Children obtained the services of Dr. John Duffy, as hearing consultant. It is a complete functioning program of hearing conservation and rehabilitation, not merely a hearing testing program. There are four major goals:

1. The earliest possible *discovery* of hearing defects in children.

2. Proper *medical care* at the earliest signs of need in order to prevent defects of hearing, and in order to restore hearing to the greatest degree possible when losses of hearing have already occurred.

Dr. W. E. Grove.

3. Proper *educational provisions* for the hearing defective child.

4. The *prevention* of diseases and conditions leading to hearing defects.

In the past year, efforts have been concentrated in about half a dozen counties, with plans to expand the program later to the rest of the state. Work began in Ozaukee, Polk and St. Croix counties where 7,126 pupils in the odd grades one through eleven were given prelimary hearing tests. Nurses, teachers, and interested women from the parent-teachers' groups were used as assistants in the screening tests.

Of the 7,126 tested, 553 or 8% were rechecked because they were found to have hearing losses significant enough to require further attention. Of this number, 106 of 1½% were selected to be given otological examinations at clinics sponsored by the local county medical society.

Each medical society selected an otologist who was a diplomate of the American Board of Otolaryngology to conduct the examinations. Eighty of the 106 children examined at the clinics were sent to their family physicians for medical follow-up and treatment. Twenty-one others were advised to obtain hearing aids.

The cost of the examinations are borne by funds from the Children's Bureau in Washington and administered through the State Board of Health and the Department of Public Instruction. Otological treatment is financed on a private basis with the family physician, except in cases where outside aid is necessary and can be obtained through local or state service agencies.

This program of screening, examination and otologic treatment is going forward in Waukesha, Milwaukee, Washington, Oneida and Vilas counties. Milwaukee, through its Hearing Rehabilitation Center, has been making progress in this field for many years.

Hearing Conservation . . . A child is examined and fitted for a hearing aid at one of the clinics conducted by county medical societies in cooperation with the Bureau of Handicapped Children.

NEWS OF VOLUNTARY PREPAYMENT PLANS

The prepaid, surgical-obstetrical Rhode Island Plan, operated through private insurance carriers, has been awarded the Seal of Acceptance by the Council on Medical Service of the AMA.

* * *

Maine and Tennessee state medical associations have voted to develop their surgical insurance plans along the private insurance carrier line. At least 10 states are now making plans to utilize this method of extending prepayament care.

* * *

Western New York Medical Plan, Buffalo, has started to repay amounts withheld from its participating physicians during the years 1941 to 1946 when pro rata payments were made. About $320,000 had been withheld over the six-year period when the doctors determined to forego their own fees to make the plan solvent. Complete repayment is expected to be made within the next year.

* * *

The Medical Service Association of Pennsylvania (Blue Shield) has completed repayment of nearly $100,000 advanced by the state medical society of Pennsylvania at the time of the plan's organization in 1940.

* * *

Individual subscribers to Blue Cross in Rochester, N. Y., now have the opportunity to become members of Blue Shield. Kansas City has had excellent experiene with this type of non-group enrollment.

* * *

Blue Shield in Montana recently extended its service benefits for subscribers by raising the income ceiling from $4,000 to $5,000. The participating physicians agreed to this liberalization in an attempt to match inflationary trends.

* * *

After months of conferences, a standard contract and administrative procedure for Blue Shield Plans having intermediat.

The VA has approved a standard contract and administrative procedure for all Blue Shield plans having intermediary contracts with the Veterans Administration for home town care.

* * *

Michigan Medical Service reported 1,052,736 members enrolled at the end of the second quarter, 1948, to become the first Blue Shield plan to pass the million mark.

* * *

More than 700,000 persons became members of Blue Shield plans in the second quarter of 1948. Total enrollment in all plans has now reached 8,624,911 members.

Radiologists Fear Attack from Within

Cite Hospital Medicine

Chicago, July 30.—Those who attack the private practice of medicine from within present a more formidable problem than those exerting external pressures for the socialization of medicine, according to the July, 1948, Newsletter of the American College of Radiology.

"The case in point is a recent statement by Dr. Frederick T. Hill in the Feb. 1948, Rhode Island Medical Journal. Ostensively discussing Group Medical Practice, Dr. Hill says, 'The Principle that the hospital should assume the responsibility for the safety and the medical care of its patients, both service and private, is now rather generally recognized.' Generally recognized by whom? To what end? This it is believed is a patent attempt to present as a fait accompli something that is neither a factor nor yet accomplished.

Vogl New Chief Medical Officer at Regional VA

Milwaukee, Aug. 9.—A native Milwaukeean, Dr. Henry L. Vogl, has succeeded Dr. H. W. Baxley as chief medical officer of the Wisconsin regional VA office in Milwaukee. He was formerly clinical director of the VA hospital at Wood.

Hereafter, suggests Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency of the State Medical Society, any doctor who has to contact the Milwaukee regional VA office for authorization for hospitalization of a veteran should ask for Dr. Vogl instead of Dr. Baxley.

BLUE CROSS GIVES FINANCIAL REPORT

The Wisconsin Blue Cross hospital care plan has more than $646,000 in reserves for future hospital cases, according to a semi-annual report issued recently by L. R. Wheeler, executive secretary.

Blue Cross in Wisconsin has a membership of 672,483 persons and currently utilizes 91½ cents of each dollar for actual benefits to subscribers, he stated. Subscriber benefits were revised last November, but Wheeler said "it is our belief that the present rates and benefits will prove adequate for a long time to come." He said 8½% of Blue Cross income is used for operating expenses.

As Good As Gold!

"Don't turn *her* over to a collection agency. She'll pay. Why, she's as good as gold!"

How often have you said this to your secretary? But such "gold" tarnishes. Then accounts pile up. Collectors take half of what should be yours. Bad feeling rises among your patients. Your secretary is swamped with extra work.

Avoid all this. Use Professional Budget Plan which is *not* a finance company, *not* a bank plan, *not* a collection agency, but a widely tested human way of handling accounts. Patients pay willingly, without resentment and without finance charges.

Make all accounts literally as good as gold. Use the Professional Budget Plan.

WRITE

Or See Us at Annual Meeting, Booth S-6, Milwaukee

PROFESSIONAL BUDGET PLAN

EXECUTIVE OFFICES MADISON, WIS.

PUBLIC RELATIONS IN PRACTICE

DO GOOD, TELL ABOUT IT . . . That is public relations. The Council on Medical Service of the State Medical Society would like to know of every instance where a county society, group of physicians, hospitals and physicians or individual physicians have taken steps to improve night and emergency medical service. If the public is to be told the full story, you've got to provide the facts. Write the Council immediately if you have a plan that is working.

PR–PR–PR–PR

Step in the right direction . . . said a Madison newspaper on Aug. 25th. Quote: Since we have been frequently critical of present day medical service, The Capital Times today takes occasion to compliment the State Medical Society for a long step in the right direction on the road to improving night service. . . . The success of any one of (the plans suggested) depends upon the wholehearted cooperation of all doctors in each county. . . . The Capital Times will be glad to lend its columns in support of this or any other movement aimed at improving what we believe to be shortcomings in medical service. Unquote.

PR–PR–PR–PR

Mr. Farmer! Protect Your Family . . . A booklet with this title is being distributed to thousands of Ohio farmers by the Ohio State Medical Association in its campaign to depict the dangers and ways to prevent brucellosis. Exhibits are being shown at the state fair and various county fairs and Fall festivals.

PR–PR–PR–PR

All the better to hear you with, my dear. . . . The Oneida–Vilas County medical society is making plans for a program to discover children with hearing defects. Physicians from Rhinelander, Tomahawk, Antigo, Phelps and Minocqua are investigating possibilities of installing a hearing program in their localities.

PR–PR–PR–PR

Good, Good Neighbor . . . The grateful community of Shullsburg recently nominated their Dr. Mary P. Gratiot for the title "good, good, neighbor of the day." A letter signed by the citizens of Shullsburg was read at a community celebration citing her 40 years of service in which she "performed far too many acts of kindness for any of us to numerate."

PR–PR–PR–PR

Found: A country doctor. . . . Many rural communities cannot attract doctors because they do not offer adequate, modern facilities needed to practice medicine. The little village of Kevil, Ky., had this problem, too, but did something about it. The community club built a neat clinic, including office, laboratory and examination rooms, etc. As a result they got a young doctor to practice in their area. He will be charged a nominal rental until the money borrowed for building materials has been repaid.

PR–PR–PR–PR

Public Relations Begins Early . . . The Waupaca County medical society is cooperating closely with the county health department in a series of classes for expectant mothers. The classes include discussions and demonstrations on health and diet during pregnancy, bathing the baby, and many other health phases.

PR–PR–PR–PR

PR gets a shot in the arm. . . . County medical societies all over the state are taking the lead in sponsoring county and city-wide immunization programs for infants, pre-school and school children. Excellent publicity has been given the programs sponsored by the Marinette Medical Society and the physicians in Barron county.

PR–PR–PR–PR

Call it the "Medical Profession" . . . The editor of the New York State Journal of Medicine thinks doctors should give up the use of the expression, "organized medicine." He says it connotes to the public the idea that physicians are organized only to further their own selfish interests, and he pledges to eliminate the expression from his columns.

Two-Day Celebration Marks Opening of First Cooperative Hospital in State

REPORT 418 MEMBERS ENROLLED; 3 DOCTORS SERVICE PLAN

Wild Rose, Wis., Aug. 23. — A two-day ceremony marked the opening of the Wild Rose Cooperative Hospital project as it became the first hospital to operate under the cooperative enabling law passed at the last regular session of the Wisconsin legislature.

The project was organized by the Waushara County Cooperative Health Association. Memberships in the hospital project were sold at $100 per member, and the August issue of the *REA News* reports that 418 memberships had been sold prior to the opening of the hospital.

The hospital was built and operated by Dr. S. L. Hadden, who sold it to the cooperative project and continues as director of the hospital. Also on the medical staff are Drs. F. G. Slattery and L. S. Shemanski.

Among the speakers at the opening ceremonies were: Acting Gov. Oscar Rennebohm, Judge G. L. Quilici, municipal court of Chicago; Dr. Donald K. Freedman, a former U. S. public health service employee; and Illinois Senator Roland V. Libonati.

Organize First State Chapter of AAGP

Neenah, Sept. 1.—The Wisconsin Academy of General Practice was organized at Neenah as 13 local physicians gathered for the first meeting of the new group.

Physicians from Neenah and Menasha have been accepted by the American Academy of General Practice and have received a charter making their group the state chapter of the AAGP.

Charter members are Drs. J. P. Canavan, Paul T. O'Brien, Richard A. Jensen, O. F. Foseid, George N. Pratt, Jr., John R. Nebel, W. B. Hildebrand, George Hildebrand, F. G. Jensen, G. R. Anderson, T. D. Smith, G. E. Forkin and Lawrence Corry.

Annual Reports of the Officers and Committees to the 1948 House of Delegates

1. REPORT OF THE COUNCIL

Detailing the activities of the Council may seem repetitious inasmuch as its minutes appear regularly in the *Journal*. The Council ordinarily meets five to six times during each year, and such will be the case this year. Much of its work is of routine character, such as passing upon special requests of various committees for special budgetary allocations, reviewing credentials of candidates for affiliate and life membership, and the like.

Under the Constitution and By-Laws, as well as by various resolutions of the House, the Council acts to supervise in general the various activities of the Society, including publication of *The Wisconsin Medical Journal*, operation of the Veterans Medical Service Agency, and reports of committees that call for action prior to scheduled meetings of the House.

The Council finds it necessary to appoint, from among its own membership or from the general membership, committees to assist in these fields. There is a monthly meeting of the Interim Committee, created to act as an exective committee between sessions of the Council. Other committees serve to review the budget and carry out functions of the open panel system, prepaid insurance through private carriers, assistance in the home town care of veterans, and similar matters.

On the whole, the chairman of the Council reports a most satisfactory state of affairs. A home for the Society has been purchased, and the various activities of the Society will be combined in the one location by the first of the year. The decision to acquire the Society building was made the more expedient by reason of the fact that not only were offices maintained in different buildings, due to the scarcity of space, but rent of adequate space had increased sharply. The Council urges the membership to visit the new headquarters in Madison after the first of the year.

Further reports of the Council will be submitted at the time of the first session of the House, after various committees of the Council have reviewed their activities with that body.

The Council reports with sorrow the deaths of the following physicians since the last annual meeting. Members of the Society are indicated by bold face type:

Report on Necrology

Allen, Jessie P. ---------- Beloit
Arneson, Thomas ---------- Almena
Baker, J. C. ---------- Hawkins
Bannen, W. E. ---------- La Crosse
Bennett, O. E. ---------- Hayward
Brown, G. V. I. ---------- Milwaukee
Buchanan, R. C. ---------- Green Bay
Caldwell, H. C. ---------- Madison
Chapman, F. M. ---------- Milwaukee
Cunningham, M. A. ---------- Janesville
Cutler, J. S. ---------- Wauwatosa
Drissen, W. H. ---------- Port Washington
Durner, U. J. ---------- Milwaukee
Egan, G. J. ---------- La Crosse
Evans, J. S. ---------- Madison
Everson, L. K. ---------- Madison
Evert, F. T. ---------- Fitchburg
Fiedler, O. A. ---------- Sheboygan
Frederick, H. F. ---------- Westfield
Froney, M. A. ---------- Sheboygan
Genter, A. E. ---------- Sheboygan
Gramling, H. J. ---------- Dousman
Hahn, C. K. ---------- Racine
Hansen, L. B. ---------- Eau Claire
Harrington, T. L. ---------- Milwaukee
Horn, A. S. ---------- Rib Lake
Housley, H. W. ---------- Mendota
Johnson, Fred ---------- Eau Claire
Jones, G. S. ---------- Genessee Depot
Kane, J. J. ---------- Prairie du Chien
Keenan, H. A. ---------- Stoughton
Kleinschmit, H. W. ---------- Oshkosh
Krembs, F. R. ---------- Stevens Point
Lindstrom, C. O. ---------- Eagle River
MacKinnon, G. E. ---------- Prentice
Mateicka, P. J. ---------- Milwaukee
McLoone, J. E. ---------- La Crosse
McNevins, E. S. ---------- Green Bay
Meany, S. G. ---------- East Troy
Meyer, M. W. ---------- Madison
Munkwitz, F. H. ---------- Milwaukee
Norton, D. M. ---------- Medford
Orchard, H. J. ---------- Superior
Parker, E. H. ---------- River Falls
Phillips, F. L. ---------- Chippewa Falls
Plahner, Samuel ---------- Milwaukee
Pohle, F. J. ---------- Madison
Post, C. C. ---------- Barron
Remer, W. H. ---------- La Crosse
Senn, C. U. ---------- Ripon
Sherwood, M. W. ---------- Milwaukee
Sickels, W. A. ---------- South Milwaukee
Siekert, H. P. ---------- Milwaukee
Somers, A. J. ---------- Chippewa Falls
Stafford, W. T. ---------- Madison
Stein, J. F. ---------- Oshkosh
Van Zanten, William ---------- Sheboygan
Vedder, J. B. ---------- Marshfield
Wasweyler, C. S. ---------- Milwaukee
Wilson, E. M. ---------- Fort Atkinson
Witte, W. C. F. ---------- Milwaukee
Woodhead, F. J. ---------- Waukesha
Woodzicka, Julia ---------- Royalton

2. REPORT OF THE SECRETARY

The secretary provides the annual report of the office in a bookkeeping sense. In the ten month period preceding August, the staff had been in attendance at more than 130 meetings, some of which, such as the two meetings of the American Medical Association, lasted over a period of several days. Reporting of these activities, providing the various committees with detailed agendas and material necessary for consideration, the mechanical details of arranging meetings, and other activities of this character draw heavily upon the staff's energy.

In addition to this type of work, the staff has matters of routine correspondence to handle, the final preparation of many reports, the business and mechanical conduct of the *Journal*, legislative and newspaper reporting and many other matters of similar activity. In a very real sense, then, the reports of many of your committees and the activities of the Society itself constitute in themselves a reporting of the work of your secretary and the office staff.

As of August 24, 1948, the membership status may be reported as follows:

1. Fully paid members	2,682
2. Partially paid members	0
3. Members in service paying no dues in 1948, or dues prorated on discharge or transfers from other states who have already paid current dues to that state society	8
4. War members who pay no dues	22
5. Resident members who pay $3	179
6. Life members; honorary members; members whose dues were waived because of temporary but serious incapacity	92
	2,983

3. REPORTS OF STANDING COMMITTEES

COMMITTEE ON CANCER

W. S. Bump, chairman; J. W. McGill; C. J. Weber, J. D. Wilkinson; D. J. Twohig; A. R. Curreri; L. W. Peterson; R. S. Baldwin; L. J. Van Hecke; T. J. Kroyer, D. C. Beebe; S. L. Henke

The primary function of the Committee on Cancer continues to be that of functioning as the Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society. As such, it meets periodically and reviews in detail the various phases of the program of lay and professional education, reporting, and research.

During the past year the Committee on Cancer has directed a number of activities which are designed to bring to the public and the profession a better understanding of the problems of cancer and the various findings of research which have bearing upon treatment.

Public Education.—In the area of public education the committee has continued to foster the development of detection centers. The progress made in this direction is not as satisfactory as might be expected. The Committee on Cancer is cognizant of the fact that successful detection centers cannot be operated in areas of scattered population, but in urbanized areas the concentration of population and of physician personnel makes the successful operation of detection centers possible.

Information centers have been set up in Marshfield, La Crosse, Eau Claire, Green Bay, Rhinelander, and Racine to determine to what extent there is a demand for literature and general information on the subject of cancer. These centers in the main are set up in connection with the public health offices and are served by members of the Field Army and the public health nurses. No professional advice is given and no recommendations are made as to physicians who should be consulted for examinations to detect cancer. The sole purpose is to make known to people the basic information regarding cancer as presented in literature approved for lay consumption, to acquaint them with resources in their community which might serve them in respect to their inquiries, and to stimulate demand for films and speakers available through the Wisconsin Division of the American Cancer Society.

Professional Education.—The Committee on Cancer through the education committee of the Wisconsin Division of the American Cancer Society has offered a number of exceptional opportunities for professional education. In November 1947 a clinic was held in Superior which attracted many members of the profession from northern Wisconsin and the Duluth, Minn., area. The success of this clinic prompted the committee to offer a second clinic in this same area, on September 15, as a joint meeting of the Eleventh Councilor District physicians and the physicians of Duluth.

In March a three day clinic on neoplastic diseases was sponsored by the State Board of Health, the University of Wisconsin, and the Wisconsin Division of the American Cancer Society. A total of 45 physicians attended this three day meeting, and the response of those in attendance was most gratifying.

Following the success of the five cancer diagnostic teaching clinics in July 1947 the Committee on Cancer sponsored a second series of meetings in July of this year. The faculty was outstanding and the subject matter of great concern to general practitioners, but the response was disappointing. So few of the practitioners of the state were reached this year even though the program could hardly be improved upon, that it is questionable whether or not the rather large funds necessary for such clinics should be spent in the future. This is a matter of great regret to the Committee on Cancer, as it was felt that the bringing of nationally prominent teachers to within a relatively few miles of the

doctors of the state was a real opportunity for the Wisconsin profession, especially since the expense was met by the Wisconsin Division of the American Cancer Society.

In addition to the special clinics conducted, the Committee on Cancer, through the Wisconsin Division of the American Cancer Society, has provided speakers on the subject of cancer for councilor district meetings and the annual meeting of the State Medical Society.

It is hoped that during the ensuing year the professional service program can be expanded so that consultation service of physicians selected by the committee will be made available to hospitals for the study of cancer problems encountered. It is felt by the Committee on Cancer that more direct professional service is needed in addition to the didactic type of clinics conducted during the past two years. While these teaching programs are of unquestioned value and are deserving of more support than accorded them, it is felt that a consultation form of service to hospital staffs might be of greater value to the profession at large. Attempts will be made during the ensuing year to implement this phase of the professional service program and determine its expansion upon the basis of experience.

Research.—The Committee on Cancer has maintained a close relationship with the research activities of McArdle Institute, and approximately $15,000 for the support of approved research projects has been authorized during the past year.

Reports.—The simplified hospital report form prepared in 1947 has been revised and distributed in quantities to all hospitals, physicians, and public institutions. The reports have been prepared so that duplicates could be conveniently supplied the State Board of Health for statistical study.

The results of the reporting program have not been entirely satisfactory to date. Efforts will be made to assist hospitals in keeping records on cancer cases and supplying the State Board of Health and the Committee on Cancer the data needed to determine the extent of the cancer problem in the state.

Recommendations

The problem of cancer is of such magnitude that it touches the practice of nearly every physician of Wisconsin. Yet, too little is known of diagnosis and treatment by many who should be well informed. It is the recommendation of the Committee on Cancer that county medical societies play a more active role in the program of professional education offered. As consultation services are provided it is hoped that the response will be one of sincere interest and not apathy. Likewise, as proposals are made for the development of detection centers it is recommended that a thorough review be made of the demand for such service, and the degree of cooperation which can be assured by the medical profession before the project is launched. The detection center has values in its favor, but it cannot succeed without careful planning and a willingness on the part of Field Army representatives as well as the physicians to give freely of their time on a voluntary basis.

The committee recommends that physicians closely identified with hospital staffs assist in encouraging better record keeping of cases of cancer treated in hospitals and in consulting with hospital administrators on methods which can be employed to give the State Board of Health the information needed to provide them with accurate statistical studies of the cancer problem in Wisconsin.

COMMITTEE ON INDUSTRIAL HEALTH

D. E. Dorchester, chairman; E. W. Miller; M. L. Jones

Basing its activities upon the report submitted to the House of Delegates in 1947, the Committee on Industrial Health has actively sponsored a series of industrial health clinics which have attracted national attention. On the basis of its experience with regional clinics conducted in 1947 the committee shaped its program this past year on the county level. Four outstandingly successful clinics were conducted in cooperation with the Rock, Outagamie, Winnebago, Dane, and Racine County Medical Societies. The clinics consisted of one day meetings, each based upon a critical review of a specific industrial operation and the ways in which management provides protection to workers against preventable injury or exposure to toxic agents.

The success of the 1948 clinics was largely due to the fine cooperation accorded the committee by the plants used for demonstration purposes: Fairbanks Morse Co. in Beloit; Kimberly–Clark in Neenah; Massey–Harris in Racine; and the Gisholt Machine Co. in Madison.

The clinics again demonstrated the intense interest of management in matters relating to industrial health. Not only did the clinics afford the 259 participating physicians an opportunity to view industrial processes, but they served as an unusually practical device for sound public relations. Labor, management, industrial nurses, the Industrial Commission, and the State Board of Health all were represented in addition to the participating doctors. Many favorable comments from members of the medical profession as well as mangement encourage the Committee on Industrial Health to recommend a continuation of the program carried out this past year.

A second activity of the Committee on Industrial Health has been the publication of a pamphlet on industrial health which has received wide acclaim both within the state and nationally. The bulletin is entitled "Industrial Health: A Guide for Medical and Nursing Personnel," which outlines recommended relationships of physicians to an industrial health program, medical ethics in industrial health, emergency procedure, and a comprehensive coverage

of care of specific injuries which are most commonly encountered in industrial practice. The latter section is of special significance, as it can form the basis for standing orders for nurses.

The bulletin was made possible by the help and financial cooperation of the Industrial Hygiene Unit of the State Board of Health. In all of its activities the Committee on Industrial Health has enjoyed the finest of cooperation from the director of the Industrial Hygiene Unit of the State Board of Health, and it is urged that this close liaison be formally expressed by having the director of the Industrial Hygiene Unit of the State Board of Health as an ex-officio member of the Committee on Industrial Health.

While much has been accomplished in the improvement of health conditions of industrial workers in Wisconsin, there are still many companies which do not conduct thorough and periodic health examinations of their workers. Partly, the cost involved has been a deterrent; also, medical records have been too cumbersome to handle without complete nursing service. It is felt by the Committee on Industrial Health that further efforts should be made to examine and re-evaluate the entire examination program, in respect to both pre-employment and periodic check-ups of workers.

It has also been noted by the Committee on Industrial Health that many small firms are reluctant to employ part time nursing service because at the present time no insurance credit is extended for this type of health service. Among the larger industries the employment of a full time nurse or more than one full time nurse is a practical part of the industrial health program, and its expense is partially underwritten by credit ratings enjoyed as a result of full time nursing service. The committee is of the opinion that some recognition should be given smaller plants if they employ part time nursing service, so as to give their employees virtually the same amount of nursing service as the greater number of employees in a plant employing full time nursing service. The committee suggests that this subject be given further study during the ensuing year.

Recommendations

1. That the general outline of the 1948 clinics be continued, with the expansion of the program into all areas of the state.

2. That county societies with industrialized areas give special attention to the contents of the publication "Industrial Health: A Guide for Medical and Nursing Personnel," so that industrial health programs will be developed along the lines suggested in this bulletin.

3. That the close working relationship between the Committee on Industrial Health of the State Medical Society and the State Board of Health be further implemented through the appointment of the director of the Industrial Hygiene Unit of the State Board of Health as an ex-officio member of the committee presenting this report.

4. That steps be taken during the ensuing year to revise the preemployment examination forms so that physicians and industrial management will be encouraged to expand this program to a far greater extent than is now the case.

5. That study be directed to current regulations governing insurance credit ratings for companies employing a full time registered nurse so that smaller companies not sufficiently large to command the services of a full time nurse might be encouraged to provide part time nursing service in keeping with their employment load. It is recommended that this matter be discussed with the Industrial Commission, the Insurance Commission, and other interested parties.

COMMITTEE ON HEARING DEFECTS

W. E. Grove, chairman; T. L. Tolan; W. B. Dimond

During the past year the Committee has had the privilege of working with the State Board of Health and the Bureau of Handicapped Children of the Department of Public Instruction in the expansion of screening programs carried out among school children of Wisconsin. The committee has been in active consultation with Mr. John Duffy, who has conducted hearing programs among the schools of Washington, Polk, and Ozaukee Counties, and has worked in cooperation with public health officials in the State Board of Health and in the Eighth Public Health District to initiate a similar type of program in northern Wisconsin.

These various programs are being developed in coordination with the committee, which has enjoyed the finest possible cooperation from Mr. Frank Powell, director of the Bureau of Handicapped Children of the Department of Public Instruction. The committee is greatly impressed with his understanding of medical problems involved in the development of such programs throughout the state.

The results of the screening programs conducted to date have been gratifying, and it is anticipated that during the ensuing year the program in northern Wisconsin will be developed more fully. The committee is at present trying to initiate a program in the Milwaukee schools, and it is hoped that a year from now it can report to the House that such a program has been undertaken.

Recommendations

In filing this report the committee submits to the House its recommendations for the further expansion of these programs:

1. It is recommended that no program be initiated without the consent of the county medical society in which the survey is to be conducted, with such consent secured through the Committee on Hearing Defects

It is further recommended that the details governing the conduct of such programs be vested in the Committee on Hearing Defects, and agencies cooperating in the program be required to clear all matters of policy through the Committee on Hearing Defects.

3. In the development of hearing defect programs, it is recommended that the use of public funds be kept in line with present policies subscribed to by the Bureau of Handicapped Children, in which families with resources shall assume responsibility for the payment of fees; if family resources are inadequate but they express a desire to assume responsibility, that community resources be utilized to supplement payment of the family; and only when private resources are lacking and community resources are not available shall state and federal funds be utilized for the development of these programs.

COMMITTEE ON MATERNAL AND CHILD WELFARE

W. C. Stewart, chairman; L. M. Simonson; E. C. Cary; R. F. Purtell; J. W. Harris; and Amy Louise Hunter.

The 1947 House of Delegates, in accepting the report of the Committee on Maternal and Child Welfare, directed the committee to make a study of Wisconsin hospital practices in maternal and child health. This survey has been completed, with exceptionally fine cooperation of the hospitals from which information was requested. More than 90 per cent of the hospitals of the state, and maternity homes known to handle a sizeable number of deliveries, responded to the request of the committee.

An analysis of the findings of this survey has prompted the Committee on Maternal and Child Welfare to make certain observations of practice in Wisconsin which it feels have direct bearing upon maternal and infant deaths.

It is obvious from the returned questionnaires that in some communities the teaching value of staff conferences is neglected. Local critical analysis of all maternal and infant deaths will do much to lessen mortality and improve medical and surgical practices. Self-criticism is a stern form of discipline, but without it the medical profession cannot hope to advance. Obviously the small hospital with a limited staff sometimes cannot hope, and may not find it necessary, to carry on the active staff meetings which are possible and highly desirable in the larger hospitals. The fact that 26 questionnaires were returned without any answer as to staff meetings and 13 others reported "irregular" meetings is not a testimony of the earnestness of the profession to probe the reasons for failure and to profit by collective thinking. The committee is appreciative of the fact that many hospitals do conduct regular meetings and work in close cooperation with pathologists to analyze mortality experienced in the hospital, but the fact that other hospitals fail to grasp this obvious opportunity for professional improvement is of concern to the committee.

> In this area it is recommended that the staff of every hospital of 10 or more physicians conduct regular staff meetings at least once a month and that it be a requirement that critical study be made of each maternal and infant death and stillbirth experienced in the hospital. It is further recommended that the Committee on Medical Education and Hospitals take steps to establish requirements which will assure this type of in-service teaching in all hospitals with 10 or more physicians on the staff.

In making this recommendation, the committee is cognizant of the fact that few hospitals outside of the larger cities are prepared to utilize full time services of a pathologist. However, by consultation and the utilization of laboratory facilities through the state, the basic information can be secured to provide the basis of study.

The care of the premature infant has been of special interest to the committee in making this study. An analysis of questionnaire returns and comparison of these with official reports in the Division of Vital Statistics of the State Board of Health indicate that too little scientific study is given this important problem. While it is acknowledged by the committee that 2 pound premature infants of 5 and 6 month gestation are often unable to respond to the best of medical and nursing care, it is lamentable to note that in 1947 there were more than 600 infant deaths among children born in the seventh or eighth month of pregnancy. It is obvious that many of these premature infants might have been saved through adequate knowledge of care and skill in medical and nursing service. Until a large percentage of premature infants in these classifications are saved, the profession cannot feel that it has attained the ultimate goal in this field of medical practice.

Efforts have been made in several states to provide a centralized nursing and medical service for premature infants, with ambulances bringing in the patients from a wide radius. This program has been encouraged by some members of the U. S. Public Health Service, but the plan does not appear to your committee as necessary or desirable in Wisconsin. The distribution of general hospitals in Wisconsin is such that adequate equipment for premature patients and a high degree of medical and nursing skill can attain the same objectives with less risk to the infant in transporting him considerable distances to a center set up for this special service. The Bureau of Maternal and Child Health is equipped to assist hospitals in providing the type of equipment essential to the best care of premature infants, and far more can be accomplished through a training program for nurses and physicians.

In this area of study, the committee recommends that every general hospital of 10 or more maternity beds provide a full service for the care of premature infants and in these hospitals that selected personnel be especially trained in the handling of children delivered before full term. It is recommended that the Bureau of Maternal and Child Health survey all hospitals equipped to render this service and set up special training community selected as a basic center for the care of premature infants. All smaller hospitals should be equipped with incubators so that the life of the premature patient can be sustained until he is taken to the nearby hospital with full equipment. This does not mean an endorsement of establishing specialized centers, but rather utilizing a considerable number of general hospitals to serve smaller areas of the state.

Hemorrhage still continues the major source of maternal deaths in Wisconsin, and it is obvious to the committee that while Wisconsin has attained a fine record in this field of medical care, there are still many lives which can be saved by alertness and diligence. Prenatal care is often neglected, when indications might point to factors which cause fatal hemorrhage. Neglect to type blood before delivery has frequently caused fatal delay and resulted in the loss of lives which might have been saved. While most hospitals have improved their blood bank reserves, there are still some where blood is not readily available and donors must be found at a time when minutes are a vital fact in recovery.

There were 83,907 live births in Wisconsin in 1947, with 87 maternal deaths, representing a very low maternal mortality rate of 1.0 in 1,000 live births. There is still an opportunity to reduce this loss of life through careful study of maternal deaths and the foreseeing of factors which might lead to prenatal or postpartum difficulties.

Most physicians now provide excellent prenatal care; however, there are still patients who do not seek care early enough, as well as those who fail to follow instructions. Physicians are urged to make efforts to have all expectant mothers examined at least once monthly until two months before time of delivery, and thereafter weekly until labor begins. In cases of anticipated difficulty patients should be given even more frequent examinations. All patients should receive easily understood instructions as to diet, rest, and exercise. It is urged that every expectant mother be furnished with materials on prenatal and infant care available through the Bureau of Maternal and Child Care of the State Board of Health.

The frequency of cesarean operation in certain parts of the state has been of concern to the committee. It is felt that in some instances the surgical procedure is resorted to without sufficient clinical evidence. It was noted that there is no degree of uniformity among hospitals concerning consultation prior to surgical treatment. The committee is of the opinion that in some instances physicians may be unduly influenced by the wishes of the patient. While the committee has little reason to feel that serious abuses have been a result of this situation, it appears that many physicians regard the procedure of cesarean section too lightly and that it is an important factor in the difficulties which have been encountered by some women after delivery. It is significant to the committee that the relative number of babies delivered by cesarean section who die or are stillborn is high enough to be of concern and bears further investigation.

The committee strongly recommends that every hospital establish an immutable rule which would require consultation by a senior member of the staff, in writing, and that consultation cannot be given by an assistant to the attending physician. The consultant should in no way share in the financial payment for services.

In reviewing the practices of hospitals in relation to maternal and child care, it has been noted that most hospitals report a low incidence of breast feeding among patients. It is felt by the Committee on Maternal and Child Welfare that the trend away from breast feeding of infants is one which should be of concern to physicians. Not only is breast feeding desirable from a nutritional and general health standpoint, but the psychologic benefits of breast feeding for both the mother and the child are of great value. It is felt by the committee that physicians, particularly in urban centers, have been prone to yield to the reluctance of young mothers to breast feed their children and that hospitals and attending physicians should take a more aggressive role in encouraging this basic form of infant feeding.

The committee urges the State Board of Health to prepare a special bulletin on breast feeding which can be distributed to mothers in hospitals, with approval of the attending physician.

The Committee on Maternal and Child Welfare has watched with interest the progress of the comprehensive study conducted by the American Academy of Pediatrics as a means of determining on a state level the current resources for the care of children and projected needs for the future. While the results for Wisconsin have not been completely tabulated at the time of this report to the House of Delegates, the initial findings point the way to certain facts which are of importance to organized medicine. Much of the material is common knowledge backed up by statistical evidence. It is apparent that the greater share of child care always has been and will continue to be a major responsibility of the general practitioner. Outside of highly urbanized areas there will be few, if any, pediatric specialists. This clearly implies a need to give greater emphasis to pediatric care in the training of general practitioners.

It is urged by the committee that those responsible for the medical education of physicians devise means whereby during the course of his training the medical student has more contact with pediatric practice and specifically that his internship concern itself with child care to a greater degree than it now does. It is further recommended that efforts be made through the State Board of Health, the medical schools, and the State Medical Society to organize a teaching consultation service in pediatrics and obstetrics.

The means whereby the objectives of the pediatric study can be achieved is one which should concern the profession. In line with the stand of the American Medical Association, the Committee on Maternal and Child Welfare expresses its unequivocal disapproval of any program which would result in federalization of medicine, which takes away from individuals their responsibility for providing medical care through the physician of their choice.

Recommendations

In concluding this report, the Committee on Maternal and Child Welfare is aware of the fact that a mere summarization of statistical findings and recommended procedures is of little practical value, without implementation. The physicians identified with hospital staffs have a responsibility for the improvement of medical practices in the institutions they serve. The Committee requests of the House in accepting this report that it direct the chairman of the Committee on Maternal and Child Welfare to transmit this report, and any pertinent data relating to the topics covered in the report, to all chiefs of staff and superintendents of Wisconsin hospitals with the recommendation that they put into practice the suggestions of the committee.

COMMITTEE ON MENTAL HYGIENE AND INSTITUTIONAL CARE

H. H. Christofferson, chairman; B. J. Hughes, O. H. Epley

The major concern of the Committee during the year concluding with this session of the House of Delegates has been the increasingly urgent problem of caring for the aged and the infirm.

Legislation designed to provide custodial care for the aged and the infirm on a county level, through the establishment of county infirmaries entirely separate from existing county mental institutions, was considered by the 1947 session of the legislature. The bill introduced was the result of joint planning between the State Medical Society and the County Judges Association. It did not receive final consideration because of the fact that it was introduced late in the session.

During the past year the Committee on Mental Hygiene and Institutional Care has met with representatives of the County Judges Association, the Wisconsin County Boards Association, and the Division of Public Assistance of the Department of Public Welfare, to gain a better understanding of the problems involved and to formulate recommendations which might be placed before the Legislative Council as a means of drafting suitable legislation in this important area of public welfare and custodial care.

A brief review of the problem will indicate the urgency for action. With advances in medical science the span of life has increased and there has been a corresponding increase in the percentage of persons who are in need of custodial care (including medical and nursing care) in the upper age brackets. The percentage has increased for the nation as a whole, and, from figures compiled by the Department of Public Welfare, it would indicate that the increase is greater in Wisconsin than in the nation as a whole. In 1870, 3.0 per cent of the United States population was 65 years and over, while at that time the percentage in Wisconsin was 2.8. By 1948 Wisconsin's percentage had increased to 8.7, while that of the United States as a whole was 7.5. If population trends continue, it is estimated that by 1975 there will be 420,000 Wisconsin persons age 65 or over, which represents 12.0 per cent of the population, while the percentage for the nation will be 11.0.

Estimates of the Division of Public Assistance indicate that there are at present 17,000 invalids in Wisconsin age 65 or over, excluding the large percentage of chronically ill, aged persons in institutions. There are many more who would be classified as "aged infirm" though not invalids, with the total of the two groups estimated to be 44,000, of which 9,000 need infirmary care. This number, with an additional 3,000 chronic invalids below the age of 65 in need of infirmary care indicates the urgency of the state providing adequate facilities for its citizens who deserve better care than an alternative of neglect or being housed in overcrowded and inadequately staffed mental institutions.

The Committee on Mental Hygiene and Institutional Care has studied the problem in great detail and, on the basis of its findings, has recommended the enactment of legislation which will meet the needs in this area of public welfare.

The enactment of permissive legislation, which will offer the means whereby counties can provide the type of infirmary care needed, will not solve the problem. Until such time as the state or federal governments assist the counties in the financing of adequate programs, there will be relatively few areas of the state financially able to implement whatever permissive legislation is enacted. Until such time as federal regulations are changed, which will continue social security payments to voluntary patients of county institutions and allow such payments to be made to the institution providing care, it will seri-

ously handicap the development of a program designed to care for the aged and chronically ill. Likewise, the state must assume financial responsibility to assist counties which do not have adequate resources to provide the quality and quantity of care required. State participation in the program is essential to its success. The problem will not grow less as the years pass, and the sooner the state and counties combine their resources to provide adequate care for this growing segment of our population, the sooner society will relieve the suffering and insecurity of many deserving citizens for which care is now inadequate.

In reviewing the problems of institutional care on the county level, the Committee on Mental Hygiene and Institutional Care has been impressed with the general inadequacy of long range planning of county institutions. It strongly recommends that efforts be made through the Department of Public Welfare and the Wisconsin County Boards Association to establish systems of uniform accounting procedures and the determination of rates of depreciation which will avoid the current trend of obsolescence without adequate resources for repairs or expansion of facilities. Likewise, assistance is badly needed to maintain adequate medical standards in many of our county institutions. In some instances the will is lacking to provide adequate care without prodding through state offices; more often the will is there but counsel is sorely needed to point the way for suggested improvements and to stimulate a dormant sense of social consciousness on the part of county officials. It is urged in the formulation of this report that the Department of Public Welfare provide trained consultation service for county institutions, and that a regular schedule of inspection and evaluation be employed in cooperation with the County Superintendents Association.

The Committee has given further study to the state institutions at Winnebago and Mendota, and the Committee recommends that the House of Delegates express its approval of current plans for complete modernization of these two institutions in conformance with recommendations made to the Department of Public Welfare by the directors of the two institutions.

There are many other areas of care for the mentally ill which have been discussed by your committee. The problem of caring for the sexual psychopath has been of concern to many in the state. Present programs are inadequate, and the committee has been disturbed to note that in some quarters it has been thought proper to treat the sexual psychopath on the same basis as the mentally ill, without proper segregation from other patients in mental hospitals. The committee feels that this form of abnormal behavior requires study and custodial care of a different nature than care given the mentally deranged person customarily housed in our county institutions, and under no circumstances should such psychopaths be housed in close contact with other patients during treatment or incarceration. The committee is of the opinion that the study and treatment of the sexual psychopath should be a legitimate function of the proposed diagnostic clinic in Madison, and it suggests when such a clinic becomes a reality and adequate facilities are provided that it assumes the responsibility of treating this group of emotionally ill persons.

The committee is cognizant of the fact that the preventive phases of mental hygiene have not been given the attention they deserve during the past year, mainly due to the urgency of considering the program of county infirmaries. The work of the Division of Mental Hygiene of the State Board of Health is of great importance to Wisconsin, and it is urged that all county societies give active support to the establishment of county mental health clinics. The program of the State Board of Health, in setting up clinics as demonstration centers and then relying upon the local community to continue the project after a period of demonstration, is one which is strongly endorsed by the Committee on Mental Hygiene and Institutional Care. Local responsibility is one which should be fostered in this age of centralization of authority and dependency upon state and federal agencies. The county mental health clinics can succeed only as physicians and social welfare agencies arouse the public to an appreciation of their value and the desirability of exercising local control over the administration of such programs. Members of county medical societies are urged to give their support to the program being carried out through the State Board of Health in this important area of preventive medicine.

Recommendations

1. The Committee on Mental Hygiene and Institutional Care recommends that the House of Delegates continue its approval of the development of a program of county infirmary care which will do more than merely open the avenue through which counties may establish facilities for the care of the aged and infirm. It must be the responsibility of the state to give the program a realistic approach by way of adequate financial support, to give reasonable assurance that many counties will take advantage of the permissive legislation provided and that steps will be taken to assure the successful operation of the program through prescribed forms of uniform accounting and methods of depreciation reserves to expand the program as new needs arise.

The committee is aware of the fact that present restrictions on the payment of social security benefits to county institutions militate against the successful development of the program contemplated. It is urged that by acceptance of this report the House of Delegates instructs its officers to direct the attention of all Wisconsin senators and congressmen to the desirability of modifying present social security regulations so that payments to voluntary patients in county institutions will be continued and can be paid to the county institution rendering care.

2. It is further recommended by your committee that a closer working relationship be established between county institutions and the Department of Public Welfare so that advisory medical consultant services can be supplied to county institutions as a means of raising standards of medical care and establishing proper methods of medical records.

3. The problem of the sexual psychopath is one which should command the attention and study of the medical profession. It is recommended that, until such time as the state diagnostic laboratory is established and has facilities adequate for the study and treatment of these emotionally disturbed people, institutions required to house the sexual psychopaths refrain from placing them in contact with other patients being care for as strictly mental patients. The committee recommends that in the development of its program the state diagnostic clinic assume the responsibility of studying and treating the sexual psychopaths.

4. The development of county mental health clinics is most important, and county medical societies are urged to give support to the development of such programs through the cooperation of the Division of Mental Health of the State Board of Health. The committee further recommends that physicians give their active support to the administration of the county mental health clinics so that the expansion of these programs will be in the hands of trained physicians rather than lay persons not well qualified to direct the medical aspects of a mental health program.

REPORT OF COMMITTEE ON GOITER

A. S. Jackson, chairman; E. W. Schacht; R. E. McDonald; C. N. Neupert (ex officio); E. S. Gordon (ex officio)

In 1946 the House of Delegates accepted the report of the committee in which the use of iodized salt was reendorsed and the committee was instructed to seek means whereby this form of protection could be assured all children in Wisconsin.

Efforts to meet with representatives of leading salt manufacturers were of no avail, and the committee awaited the efforts of the Council on Foods and Nutrition of the American Medical Association to have legislation passed by Congress which would establish rules of manufacture on a national scale. After two years of study and effort, a bill was presented to the House Interstate and Foreign Commerce Committee which would have required the universal manufacture and distribution of iodized salt, and still provided a salt free of iodine which could be used on special prescription for those who had valid objections to the use of iodized salt. This bill was rejected by the House Interstate and Foreign Commerce Committee, and thus the situation remains the same as it has for many years.

Recognizing the improbability of securing legislation in this field on a state basis, the committee has intensified its efforts to encourage the use of iodine tablets in the public schools. During the past year the committee has contacted all school officials and health committees of county boards to ascertain the extent of coverage and to advocate the continued use of iodine tablets until such time as the use of iodized salt is general enough to give assurance that children are being given the protection needed.

The results of this survey are enlightening and provide sufficient data to determine the recommendations of the committee to the House of Delegates. Returns from county superintendents indicate that well over 90 per cent of the rural children are given iodine tablets, generally supplied to teachers by the county nurse, who in turn has purchased the tablets from funds provided by the health committees of county boards. On the other hand, in urbanized areas the coverage is very low. Reports were received from 102 of the 106 cities classified as city superintendencies. Of those reporting, 68 have goiter control programs and 33 do not; but of the 68 which have programs the majority are the smaller school systems. Such large urbanized areas as Appleton, Beloit, Chippewa Falls, Cudahy, Janesville, Kenosha, La Crosse, Madison, Manitowoc, Milwaukee, Racine, Sheboygan, Superior, and West Allis are without goiter control programs according to reports filed with the committee. Only 24.4 per cent of the children under the direction of city superintendents are given protection through iodine tablet programs, and, of the schools reporting a positive program, many neglect to carry the distribution of tablets beyond the elementary level. In the main, the schools which receive tablets through the county nurse and do not have to provide funds for the service are the areas which give their children the protection advocated by this committee.

Coverage in the villages indicates that less than 40 per cent of the children attending elementary and high schools in communities less than 5,000 in popuulations are provided with iodine tablets, and in most instances the programs which do exist terminate at the end of the eighth grade.

Combining the statistics gathered in the various classifications, the Committee on Goiter is impressed with several findings:

1. In rural areas, where public health nurses are in closest contact with schools and where funds are supplied through the health committees of county boards, the majority of children are now receiving iodine tablets during the course of the school year, but such service is generally terminated at the eighth grade level.

2. In urbanized areas the coverage is relatively low, and with few exceptions the coverage terminates at the junior high school level.

It is the opinion of the Committee on Goiter that the medical profession should be sufficiently interested in this program of preventive medicine to give it active support. When contacting school officials, the committee has continued to emphasize the desirability of consultation with county medical societies, as a means of localizing control. From some returns received in the recent survey, the committee is disturbed to learn that in some instances the local medical authorities consulted have given the impression that a program of this character was unnecessary or even undesirable. Possibly this was a misinterpretation on the part of the school administrators reporting, but under any circumstances the

Committee on Goiter urges local health officials and county medical societies to encourage the continuation of the iodine tablet program until such time as the general use of iodized salt is assured.

In order to give direction to the goiter control program, it is recommended to the House of Delegates that the Committe on Goiter issue a simply worded explanation of the desirability for protection and indicate recommended procedures to follow. It is felt that if this type of pamphlet is widely distributed among schools, county boards, Parent-Teacher Associations, and other interested groups there will be a better understanding of the problem and a greater degree of uniformity of practice among the schools now distributing iodine tablets.

Recommendations

Even though Wisconsin has made notable progress in goiter control through an expanded use of iodine tablets among school children, it is urged that further steps be taken through the American Medical Association and the United States Public Health Association to devise legislation which will require the manufacturers of salt to fortify all grades of table salt with iodine, except for a special purpose salt which will be available on prescription for those few individuals who in the opinion of physicians react unfavorably to iodine.

In making its recommendations for intensified efforts for expansion of the goiter control program through the use of iodized tablets, the committee urges all county societies, and particularly those in communities not now having a control program, to lend their support to the procedures being advocated by the committee to school boards, public health nurses, and school administrators. Further progress in this field cannot be assured unless the medical profession has an appreciation of the advisability of distributing iodine tablets in the schools until such time as the use of iodized salt is so general that other methods of supplementing the diet with iodine can be discontinued.

COMMITTEE ON HOSPITAL RELATIONS

A. J. McCarey, chairman; J. E. Habbe; M. L. Jones; J. W. Smith; R. M. Waters; Gorton Ritchie

The Committee on Hospital Relations, in cooperation with the Wisconsin Hospital Association, sponsored the first of what it is hoped will become a series of regional conferences, at Green Bay on April 8. The attendance of 81 hospital directors, nursing supervisors and other personnel; 53 physicians; and 6 hospital trustees was an encouraging beginning of a program designed to establish better working relationships between hospital administrators and the physicians of the state.

The program was planned by officers of the Wisconsin Hospital Association after consultation with the Committee on Hospital Relations. Topics covered included "X-ray Screening Procedures," the "Interrelationships of Hospital Staff and Hospital Administration in Public Relations," "Skilled and Semi-Skilled Nursing Personnel," and "The Organization of the Hospital and Medical Staff, For Effective Service to the Public."

The success of this initial conference prompts the Committee on Hospital Relations to recommend that similar meetings in other areas of the state be developed during the ensuing year.

COMMITTEE ON RURAL HEALTH AND ACCIDENT PREVENTION

R. L. MacCornack, chairman; J. J. Minahan; A. A. Filek

The problems of rural medicine are still with us, and little in a concrete way has been done during the past year to solve the problem in Wisconsin. The Committee on Rural Health has consulted with representatives of the Committee on Rural Medical Service of the American Medical Association to determine what might be accomplished through the agency of a state conference on rural health and what the content of the program might be. Conferences with rural leaders on a state and county basis have been urged by the American Medical Association, and the Committee on Rural Health and Accident Prevention hopes to initiate such a conference during the ensuing year.

From contacts with farm representatives, the Committee on Rural Health is aware of the fact that the two most pressing problems in rural areas are the inability of rural communities to attract physicians and the difficulties of expanding health insurance coverage in rural areas. The committee sees no immediate change in the first problem, as the distribution of physicians is determined by factors far more involved than mere economic return. During these days of post-war prosperity the average rural practice has been relatively lucrative, but such factors as schooling, separation from social and cultural contacts commonly found in urbanized areas, lack of hospital facilities, or inability to secure beds in existing hospitals all play their part in problems of rural medical practice. But while no immediate improvements are likely, it appears to the committee as highly desirable to have a conference between leaders of the medical profession and representatives of farm organizations so that there can be a free exchange of ideas and a better understanding of the attitudes of all groups concerned with the health and welfare of those citizens of Wisconsin residing in rural areas.

The Committee on Rural Health is pleased to note the encouraging expansion of the insurance pro-

grams among the rural population of the state. The fine cooperation of the Farm Bureau in bringing the benefits of the Wisconsin Plan to its many members has done much to acquaint farm families in Wisconsin with the coverage available. Likewise, the sales efforts of Wisconsin Physicians Service and Blue Cross in selected rural areas of the state indicate a real interest of farm people in securing coverage provided through the services of the State Medical Society of Wisconsin.

The continuation of the 4-H Health program has been of great satisfaction to the Committee on Rural Health. Each fall, funds through the committee are made available for scholarships for the 4-H Leadership Camp, and in the spring a representative of the 4-H clubs selected by state 4-H leaders is sent to the national 4–H congress under the sponsorship of the State Medical Society of Wisconsin. Many young people have been touched by this program of financial help in the past, and its continuation is urged by the committee presenting this report to the House of Delegates.

Recommendations

1. That during the ensuing year an initial state rural health conference be sponsored by the Committee on Rural Health and Accident Prevention of the State Medical Society, after consultation with leaders of farm organizations, who would assist with the formulation of the program and work with the committee in stimulating participation by all groups concerned with problems of rural health.

2. That the contacts established with 4-H clubs be continued and financial assistance be given to encourage young people to develop health projects as a part of their 4–H club activities.

ADVISORY COMMITTEE ON THE CARE OF CRIPPLED CHILDREN

H. A. Sincock, chairman; M. H. Steen; A. B. Schwartz; W. P. Blount; C. M. Kurtz; C. M. Ihle

Functioning as an advisory committee on all medical matters confronting the Bureau of Handicapped Children of the Department of Public Instruction, this committee has consulted with the director of the bureau on various matters during the course of the year.

As the bureau is the recipient of funds through the Children's Bureau in Washington, there is a recurring problem of suggested regulations governing the spending of these federal funds. The director of the Bureau of Handicapped Children, Mr. Frank Powell, has on numerous occasions demonstrated his desire to administer his program along lines suggested by the physicians of Wisconsin rather than by mandates handed down from Washington. During the past year he has been confronted with recommendations that a set fee schedule for medical services be established, but he has rather chosen to determine payments on individual cases, taking into account such factors as the patient's ability to participate in the payment of the medical fee, the specialized work involved, and other factors which can be given recognition only in a fee schedule with some degree of elasticity. It has been the philosophy of the Bureau of Handicapped Children, approved by the advisory committee, that whenever possible patients should participate in the payment of medical fees. The committee has approved the present policy of maintaining an elastic fee schedule, with the rehabilitation schedule used as a basis for payment.

The committee has reviewed suggestions made by Children's Bureau urging changes in state laws so that probate judges would have powers of determination in cases involving handicapped children. After discussing the situation with the director of the Bureau for Handicapped Children and being acquainted with the fine relationships which exist between the personnel of the Bureau and probate judges of the state, it was the consensus of the committee that the present regulations be retained without changes in the laws of Wisconsin.

Review of the orthopedic clinic program indicates that this service is being rendered to the satisfaction of all parties concerned. During the year 1947 there were 33 clinics held, serving 1,620 children, and the giving of 2,107 examinations. Due to care in screening patient applicants there is a decrease in the number of repeaters for examination, so that a greater number of new patients are being examined each year. The committee has been aware that in many instances patients are referred back to physicians designated as family physicians, but who have not seen the patient in years, so it has been recommended that the bureau devise means whereby follow-up examinations can be made with the payment of funds through the bureau only in those instances in which local or family resources are not available to adequately finance the necessary follow-up work.

The committee is aware of the fact that to date little has been done to scientifically measure the abilities and needs of an estimated 2,000 children in Wisconsin suffering from cerebral palsy. The type of clinic conducted for orthopedic patients would be inadequate for a thorough study of the spastic child. The committee is impressed with the fact that the need in this segment of medical practice cannot be met without a well equipped diagnostic clinic where patients can be studied for a number of days, and even weeks, to determine the degree of educatability of the patient and recommendations for therapy or custodial care. It is urged that this problem be given special attention by the bureau and the advisory committee during the ensuing year.

Wisconsin is falling behind in the development of its rheumatic fever program. Sufficient research has been conducted to provide a sound basis for the

development of a state-wide program of therapy and care. The committee has already issued a set of minimal standards for the operation of a convalescent home for rheumatic fever patients. What is strongly needed is state support which will give impetus to local programs based upon the standards outlined by the advisory committee. It is anticipated that the 1949 session of the legislature will be asked to consider the problem, and the advisory committee strongly urges that through the acceptance of this report the House of Delegates endorse the principle of developing a statewide program for the care and treatment of rheumatic fever patients, with the state participating in the financial support of such a program. Such local programs should be supported on condition that they meet the minimal standards subscribed to by the medical profession through acceptance of the report of the advisory committee to the 1947 House of Delegates.

Recommendations

In reviewing the general conduct of the medical program of the Bureau of Handicapped Children, the advisory committee has little to recommend other than continuation of present policies and the development of more complete programs for children suffering from cerebral palsy and rheumatic fever. The medical profession of Wisconsin can consider itself fortunate to have a person of the caliber of Mr. Powell in the role of director of the bureau. He has established the finest of working relationships with the medical profession, and, largely through his efforts, these programs have been developed with the help of federal funds, still retaining control on the local level. His philosophy of rendering assistance where most needed and in keeping with principles of patient participation in meeting medical costs is one which is sorely lacking in many of the federal programs which undermine through misdirected philanthropy the dignity and independence of the recipients of federal aid.

In presenting this report the advisory committee commends Mr. Powell for the quality of the program conducted under his direction and expresses appreciation of the entire profession for the maintenance of sound professional relations in all phases of his work.

COUNCIL ON SCIENTIFIC WORK

C. F. Midelfort, chairman; E. R. Schmidt; J. M. Freeman; F. W. Madison; W. S. Bump; W. S. Middleton (ex officio); J. S. Hirschboeck (ex officio); K. H. Doege (ex officio)

The Council, in presenting its report to the 1948 session of the House of Delegates, is pleased to call attention to a wide variety of scientific activities which have been directed by it and appropriate committees of the State Medical Society during the year 1947–1948.

The principle of extending scientific services to the membership of the State Society has been one of its major responsibilities. This year postgraduate clinics numbered 12, of which 4 were industrial health clinics held in cooperation with the Committee on Industrial Health and the Racine, Outagamie, Winnebago, Rock and, Dane County societies; 3 were in the nature of general refresher clinics covering the fields of obstetrics, pediatrics, endocrinology, and surgery, presented in La Crosse, Wausau, and Manitowoc; and, in cooperation with the Committee on Cancer and the Wisconsin Division of the American Cancer Society, the Council presented 5 cancer clinics in Racine, Fond du Lac, Stevens Point, La Crosse, and Janesville.

A total of more than 1,000 physicians attended these clinics, and, from comments of these who participated, the Council has reason to believe that this type of service is a vital part of the activities of the State Medical Society.

As a means of stimulating interest in councilor district meetings, the Council on Scientific Work has initiated a program of supplying speakers, in cooperation with the State Board of Health, the Wisconsin Division of the American Cancer Society, the Bureau of Handicapped Children of the Department of Public Instruction, and the Department of Public Welfare. Several of the districts utilized this speaking service, and more programs of this character can be provided for the benefit of members during the ensuing year.

The development of the scientific program for the Annual Meeting is a direct responsibility of the Council. The program for 1948 has been prepared under the general direction of Dr. E. R. Schmidt. He has been assisted in the development of the scientific programs for the sections by Drs. Woodruff Smith, Ladysmith; Elwood Mason, Milwaukee; Carl S. Harper, Madison; J. K. Trumbo, Wausau; M. G. Peterman, Milwaukee; S. R. Beatty, Oshkosh; and Frank D. Weeks, Ashland. Scientific motion pictures have been provided through the cooperation of Dr. H. Kent Tenney, Madison, while Dr. F. W. Madison, Milwaukee, has been in charge of the scientific exhibits.

During the year several matters of a scientific character have been referred to the Council for study. One has related to the matter of autopsies, and the Council is working with the state pathologists and the funeral directors to secure a better understanding of the two groups involved in the problems which have arisen.

Recommendations

The Council on Scientific Work in presenting its report has little to recommend except that all efforts be made to stimulate continued interest in scientific programs sponsored by the State Medical Society of Wisconsin. The development of such programs rests largely upon the cooperation of county officers and

those most interested in scientific medicine to stimulate interest among those physicians who give little attention to this phase of the State Society's activity. Physicians who are nationally known as clinicians and teachers are brought to Wisconsin as participants in these programs; they give generously of their time and effort to render this service to the physicians of Wisconsin. Their contributions to scientific knowledge of Wisconsin physicians provide opportunities which should not be under-estimated, and the Council enlists the aid of all delegates in stimulating participation in the various scientific programs developed.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

L. O. Simenstad, chairman; J. D. Steele; A. A. Pleyte

The detection of tuberculosis continues through the efforts of the State Board of Health and the Wisconsin Anti-Tuberculosis Association. The State Board of Health reports 109,000 x-rays taken by mobile units in 1947, while the Wisconsin Anti-Tuberculosis Association reported 55,000 x-rays taken in 1947, with 1 per cent of clinical significance as against 1.4 per cent in the experience of the State Board of Health.

The reporting of cases to the State Board of Health has not been as complete as desired, with only 9 per cent of the cases report coming direct from physicians. The committee has recommended that, in sending reports from the Wisconsin Anti-Tuberculosis Association to family physicians, it be emphasized that positive findings are to be reported to the State Board of Health for statistical data.

The committee has given special attention to establishment of procedure which will better coordinate the work of the State Board of Health and the Wisconsin Anti-Tuberculosis Association in the field of tuberculosis control. It has been agreed that as more direct service is available through the State Board of Health, the Anti-Tuberculosis Association will confine its activity to education and coordination with the service program of the State Board of Health.

Special attention has been directed to a proposal that the State Board of Health provide diagnostic services as a service to physicians. The committee disapproves of an expansion of state services except in cases in which local facilities are inadequate for diagnostic service. It is recommended by the commttee that the State Board of Health should make itself available for consultation service, but it should not expand its direct diagnostic facilities in communties where such services can be adequately rendered by practicing physicians.

The routine x-ray examination of all hospital admissions for the detection of tuberculosis has been utilized by several general hospitals in the state, and, from reports submitted to the Committee on Tuberculosis and Chest Diseases, it would appear that such a program is of value in hospitals with sufficient admissions to utilize the services of a radiologist. However, as yet there has been no agreement as to the charges which should be made for this procedure. It would appear that in some instances hospitals are charging an amount which provides some revenue over and above the actual cost of equipment, film, and reading service of the radiologist. The committee feels that any charge beyond actual cost is not justified and defeats the purpose of the program as one of preventive medicine and protection of hospital personnel against contacts of infection not anticipated upon admission of patients. It is urged that hospitals and radiologists establish procedures and charges which will meet all costs without using this service as a source of revenue to the hospital rendering the service.

There are many problems of tuberculosis and chest diseases which are still before the medical profession. The use of newer drugs, the care of the tubercular in our mental institutions, and many other problems are still to be considered by the Committee on Tuberculosis and Chest Diseases during the ensuing year. While the program of control has improved through expanded facilities of the State Board of Health and Wisconsin Anti-Tuberculosis Association, there is still work to be done by this committee in the years ahead.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Norbert Enzer, chairman; E. R. Krumbiegel; and L. R. Cole

The activities of the Committee on Health and Public Instruction have continued to make a valuable contribution to the public relations program of the State Medical Society, particularly in the fields of radio and press. These activities have been expanded in response to the public demand for reliable and practical information concerning health and medicine.

Radio.—The State Medical Society's public service radio program, "The March of Medicine," has continued to grow and enjoy success among the radio stations of Wisconsin and their listening audiences.

In the past year three more stations have been added to the list of those carrying the program. In each case the request came spontaneously from the station itself, and none was the result of a definite effort to recruit more stations. This brings the total number of stations to twenty-five.

The stations now carrying the program are: WHBY, Appleton; WATW, Ashland; WBEL, Beloit; WEAU, Eau Claire; KFIZ, Fond du Lac; WTAQ, Green Bay; WIKB, Iron Mountain; WJMS, Ironwood; WLIP, Kenosha; WKBH, La Crosse;

WIBA, Madison; WOMT, Manitowoc; WLDY, Ladysmith; WMAM, Marinette; WDLB, Marshfield; WIGM, Medford; WEMP, Milwaukee; WNAM, Neenah; WOSH, Oshkosh; WOBT, Rhinelander; WJMC, Rice Lake; WHBL, Sheboygan; WLBL, Stevens Point; WSBR, Superior; WAUX, Waukesha.

Each station carries "The March of Medicine" for a fifteen minute period every week as a public service feature. The unusually fine cooperation of the radio stations of Wisconsin in presenting this program is demonstrated by the fact that a total of 325 hours of broadcast time are provided each year for the series. This time, if it were to be purchased at commercial rates, can be conservatively valued at more than $30,000.

Using the fan mail received from listeners as the measuring stick of the program's listening audience, it is apparent that these 25 stations provide excellent coverage of the state. Mail responses have come from 70 of the 71 counties and from more than 300 communities, including towns in Indiana, Illinois, Iowa, Michigan, and Minnesota.

The fan mail indicates that there is still a termendous need for health education material throughout the state and reveals the extent of misinformation in the minds of lay persons. The letters show continued need for improved relationship between patient and physician.

That the radio station directors consider this program worth while is shown by the fact that 11 stations have begun their fourth continuous year with "The March of Medicine" and only one station felt it necessary to discontinue the program because of a pressing schedule. However, this station has indicated that it will be interested in resuming the program as soon as their schedule permits.

Much of the success of these programs is due to the services of Doctor Cole, who writes and presents each program in the weekly series with the exception of occasional talks by guest speakers or interviews with others. In addition, Doctor Cole makes many personal visits to radio stations to present "live" broadcasts.

The committee feels that the public relations value of this program is quite obvious to the House of Delegates and recommends its continued development.

Press.—Weekly health releases are sent to all Wisconsin newspapers on subjects which have a personal appeal as well as presenting authoritative and helpful information regarding health and medicine. Every opportunity is being utilized to improve press relations through direct contacts with the editors of dailies and weeklies in Wisconsin so that these media directors have a better understanding of the aims of the State Medical Society's health education program. A great number of the state's newspapers have given outstanding cooperation to this program, and a recent letter to each editor commended them for this service in the interest of public health.

A bi-monthly article, written by Doctor Cole, is published by *The Wisconsin Agriculturist and Farmer*, a publication with more than 185,000 farm readers. This column has wide reader interest, and is sometimes used as a means of soliciting requests for pamphlets and publications on health matters of particular interest to Wisconsin's rural residents.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

R. G. Arveson, chairman; C. R. Marquardt; P. M. Currer; J. S. Supernaw; J. W. McGill; President (ex officio); Past-President (ex officio); Chairman of the Council (ex officio); Speaker of the House of Delegates (ex officio).

The past year has been one of development and expansion of the public relations activities of the State Medical Society of Wisconsin. Efforts have been directed toward improving the State Medical Society's service to the profession as well as to the public.

The possibilities are great for an expanded public relations program that will be highly beneficial to the profession and the public. The Council finds that the public and inter-professional relations are so involved in almost every phase of the State Medical Society's activities that it is difficult to know where its efforts should begin or end. One of the greatest needs of the profession in this state is the formation of a series of broad principles to guide our effort, define our objectives, and outline the activities by which we seek to achieve good public relations. Most of all, good public relations is good public service. Good public relations means that the activities of the profession must be planned and executed for the benefit of all the community, and the community must be kept informed of the facts. Public opinion must be taken into account in all actions and the public benefit made an important factor in all decisions. At the same time, if the profession's efforts are to be appreciated and rewarded through good public relations, the public must be told the facts.

The agency through which the medical profession can most effectively assure health leadership and plan, execute, and publicize sound health programs is the county medical society. Its officers and members are most familiar with the needs and problems of their community. They have the power to recruit and influence their activities toward coordination of the statewide effort.

The first step in this direction is, therefore, the establishment by every county medical society of a public relations committee. These already exist in many societies. The functions of such a committee can be performed by the committee on public policy if the creation of an additional committee is not desired by some societies.

The Council named the personnel for the subcommittees whose reports follow this review of the overall activities of the parent committee.

Emergency Medical Care.—Probably one of the most important developments of the year, from the public relations standpoint, was the action of the Council in urging all physicians, groups of physicians, and county medical societies to take immediate steps to establish methods whereby the public can be assured that night calls and calls for emergency medical care will be handled quickly and effectively. Wisconsin physicians as well as those in other parts of the country have been the subject of some criticism regarding inability of patients to secure medical service at night or in emergencies. While this criticism is not justified to the extent claimed, and the public itself is partly to blame for the condition, it was felt that there was an urgent need for each physician and county medical society to make a positive demonstration of their willingness and ability to solve the problem wherever it exists.

Accordingly, each county medical society was advised to study its own situation and take appropriate steps to remedy the problem, if no measures had already been taken to do so, or to prevent such a problem from developing.

While it is too early to appraise the results of this action, it is your Council's hope that the House of Delegates will add its support to the program.

Special Committee.—The Legislative Council of Wisconsin, which has been engaged in a survey of all state departments and agencies, last March requested the State Medical Society to provide the advice of a special committee composed of individuals skilled in public health administration, organization technics, business management, and general health projects to make a detailed study of the organizations, functions, and responsibility of the State Board of Health. Upon completion of the study, the special committee was to report to the Legislative Council.

The Council on Medical Service and Public Relations appointed the following members to the special committee: Dr. Carl D. Neidhold, Appleton; Dr. H. Kent Tenney, Madison; Dr. W. W. Bauer, Chicago, director of the Bureau of Health Education of the American Medical Association; Dr. Gaylord W. Anderson, Minneapolis, director of the Minnesota School of Public Health; and a representative of the Northwestern Mutual Life Insurance Company. The chairman of the Council on Medical Service and Public Relations and the secretary of the State Medical Society served as ex officio members.

The special committee met a number of times and spent many strenuous hours in consultation with personnel of the State Board of Health and many other individuals. A voluminous report has been completed and will be submitted to the Legislative Council at an early date.

A great amount of time, effort, and serious consideration has gone into the making of this study, and the Council expresses its deep appreciation to the committee for its very careful and complete report. Inasmuch as the Legislative Council saw fit to request the State Medical Society to make this study, your Council looks at this evidence of confidence as reflecting considerable credit upon the medical profession of the state.

Secretaries' Conferences.—Your Council approved and planned four regional conferences for officers, committeemen, and delegates of county medical societies to acquaint them more closely with activities of the Society and bring them information on medical economic affairs and public relations problems and technics.

Conferences were held as follows: Fond du Lac, May 26, for First, Second, Fifth, Sixth, and Twelfth Councilor Districts; Baraboo, May 27, for Third, Fourth, and Seventh Districts; Wausau, June 2, for Eighth, Ninth, and Thirteenth Districts, and Rice Lake, June 3, for Tenth and Eleventh Districts.

While the attendance left much to be desired, the program was both thought-provoking and informative, and a request for suggestions for future conferences brought nearly 50 letters, most of which expressed satisfaction with the meetings and hopes for their continuance. The Council feels that future meetings should permit more informal discussion and center on the problems of local county societies.

Press.—While press clippings are no indication of the success of a public relations program, the newspapers of Wisconsin provide one of the most important mediums through which the public can be made aware of its responsibility for good health, scientific advancement in medicine, and health conditions in local communities, and by which the health education of the public can be carried out.

In the past year, there has been increased cooperation with the state press with the result that the story of medicine is being told more widely than ever before. Newspapers and news services have been extremely helpful and cooperative in the preparation and use of material in the press.

Advance newspaper releases were sent to all newspapers in Wisconsin on the Annual Meeting, Cancer clinics, Postgraduate Education clinics, and Industrial Health conferences and to selected newspapers on scores of other meetings. Special releases were sent out to local newspapers about speakers at these meetings, and special releases were prepared on all scientific papers at the Annual Meeting in which it was felt there would be public interest. A special feature on the history of the medical society was written at the request of one newspaper, and an increased number of newspapers and newspapermen came to the Society for information in the preparation of articles concerning health and medicine. Scientific articles in *The Wisconsin Medical Journal* are abstracted and rewritten in lay terminology and receive wide publication.

Nearly 100 news releases were prepared and sent cut by the State Medical Society in the past year. A large proportion of these were special releases for

local newspapers. The articles have appeared regularly in a high percentage of the state's daily and weekly newspapers.

Personal Contacts.—The Council and the staff member assigned to carry out the activities of the Council have been in personal contact with increasing numbers of persons in lay organizations; mediums of communication, including radio, newspapers, and magazines; medical organizations; health and educational groups; governmental officials; and important individuals in the business and professional world. Among the major contacts made in this field were those developed at the United States Chamber of Commerce dinner with state senators and representatives and at the National Health Assembly in Washington.

Supplying Printed Materials.—Each year a substantial number of requests are directed to the Society by lay persons seeking information concerning health and medicine or voluntary and compulsory health insurance plans. Many of these are from high school and college students; others are from influential lay leaders in various fields. These requests are filled either by loan packets or packets of up-to-date information which the person may keep. It is felt that it is highly important that these requests be fulfilled with the best materials that are available.

Medical Forum in The Wisconsin Medical Journal.—This 8-page section of *The Wisconsin Medical Journal* is devoted exclusively to matters of medical economics and public relations. Every effort has been made to include in this section up-to-date information on the development of the Society's prepayment medical and surgical care plans, the Wisconsin Veterans Medical Service Agency, and helpful information regarding public relations. Starting with the August 1948 issue, two full columns of the Medical Forum will be devoted to "Public Relations in Practice," a timely, informative summary of what the county medical societies are doing in the way of public relations. It is hoped that this will supply all county medical societies with practical help in this phase of medical activity.

Local Public Health Councils.—The formation of the Wisconsin Public Health Council in July was given the unanimous endorsement of the Council on Medical Service and Public Relations and the General Council as a means for integrating various lay, professional, and official forces in the health field for the improvement of community health and welfare. Dr. W. D. Stovall, president of the State Medical Society, and the secretary of the Society are on the Wisconsin Public Health Council's Board of Directors. Your Council urges the establishment of local county public health councils and is undertaking an information program for physicians so that they may be acquainted with this rapidly growing movement and be prepared to cooperate fully in any efforts to improve the health of the people of Wisconsin.

Cooperation with Other Committees and Agencies.—Your Council is working closely with all State Medical Society committees wherever cooperation or assistance is needed or possible. The Council has given considerable support to the activities of the Committee on Rural Health and the Committee on Health and Public Instruction.

The Council also wishes to draw attention to the value of intraprofessional and public relations resulting from of the formation of the "50 Year Club" at the last Annual Meeting, and the presentation of the 50 year gold pin and engraved certificate to its members since that time. The many letters of appreciation from members so honored as well as the widespread publicity given these physicians by the state press indicate a growing interest in the project. The 50 Year Club is an excellent expression of the long and devoted service given to the people of Wisconsin by their physicians and provides a means of showing the great advance in medicine and health of the last half century.

Rebates.—Your Council has given careful consideration to the charges that some physicians have engaged in the practice of accepting rebates. While it is evident that the practie of rebating has decreased, there is necessity for continuing efforts toward ridding the medical profession of this practice.

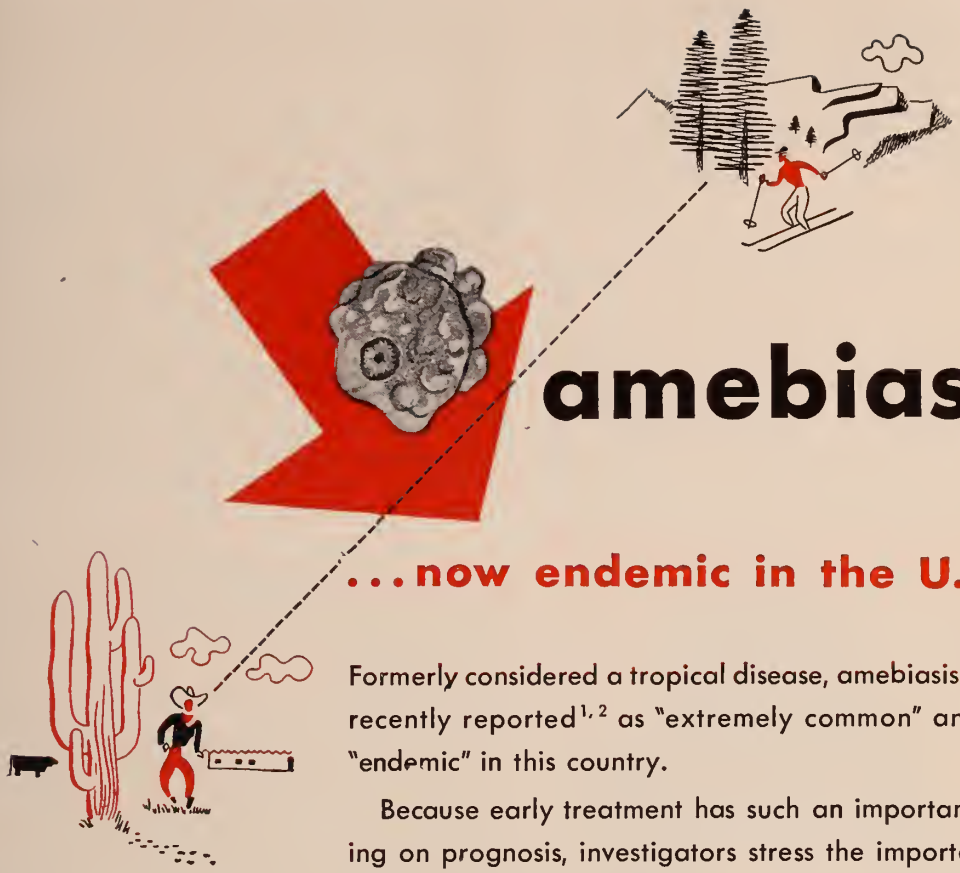
The Council concurs in the position of the American Medical Association on this matter, and recommends that, upon satisfactory proof that a physician is engaged in the practice of rebating, disciplinary action shall be initiated by the county medical society of which he is a member. It is further recommended that if no disciplinary measures are instituted by the county medical society in such cases, the matter be referred to the Council of the State Medical Society for action.

Terms of Delegates.—In accordance with the action of the House of Delegates of the American Medical Association at its last meeting, the Council recommends that terms of office of the delegates of the State Medical Society of Wisconsin to the House of Delegates of the American Medical Association begin on January 1.

Sub-Committee on Wisconsin Interscholastic Athletic Association

Members: J. S. Supernaw, chairman; C. M. Carney; W. R. Manz; H. F. Schroeder; and A. C. Schmidt

In presenting this report, the subcommittee on WIAA wishes to review briefly the background which led to its creation. For many years the Wisconsin Interscholastic Atheletic Association has maintained a benefit program designed to share in part the cost of medical and hospital expenses incurred in connection with injuries sustained in school athletic activities. During the course of developing the program, the physicians of the state were consulted on various matters, including the



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RESEARCH
IN THE SERVICE
OF MEDICINE

1. Chalgren, W. S., and Baker, A. B.: Tropical Diseases: Involvement of Nervous System, Arch. Path. 41:66 (Jan.) 1946.
2. Browne, D. C.; McHardy, G., and Spellberg, M. A.: Statistical Evaluation of Amebiasis, Gastroenterology 4:154 (Feb.) 1945.
3. Mansan-Bahr, P.: Some Tropical Diseases in General Practice: "A Post-War Legacy," Glasgow M. J. 27:123 (May) 1946.

schedule of benefits and the medical regulations establishing eligibility for participation in the benefits provided. During the years of its operation the WIAA program has expanded its coverage to cover all forms of school activities and provide benefits for a wide variety of injuries sustained on school grounds by children not engaged in formal athletic competition.

Since its inception, the WIAA plan has raised many questions in the minds of physicians called upon to treat injuries of students covered by the program. In many instances there were misunderstandings of regulations which led to complaints filed with the office of the State Medical Society.

In response to an obvious need for a closer working relationship between the WIAA program and the State Medical Society of Wisconsin, the Council on Medical Service and Public Relations was asked to set up a special subcommittee with one of its members, Dr. J. S. Supernaw, Madison, as chairman.

The various meetings with officials of the WIAA have produced a better understanding of the difficulties which have occurred in the past and will result in changed procedures of payment which should prove highly satisfactory to the physicians in Wisconsin. At present time heretofore payments were made to school officials who paid the hospital and physician's bills; now the bills for hospital and medical care are rendered separately and in accordance with specific authorizations for treatment furnished. The schedule of benefits have been materially changed and in general follow the schedule of benefits which are accepted as full payment under the Veterans Medical Service program. While publicity directed to parents in the past has stated that the schedule of benefits did not represent full payment in cases requiring unusual care, the present publicity is more specific on this point and should do a great deal to correct the misimpression that the benefit program was the form of insurance which freed the parent from any responsibility for supplementary billing by the attending physician.

It is of satisfaction to note at this point in the report that the WIAA, largely at the insistence of the physicians serving on the subcommittee is now making a complete actuarial study of its operations to determine a rate adequate to meet all benefit payments. This special committee is composed of a staff member of the state insurance commission, two experienced insurance officials and officers of the WIAA.

Another area of WIAA activity which has been given special study by the subcommittee is that of the medical regulations governing the time limits which must be observed before a student injured in athletic competition is permitted to resume competition in order to become eligible for the benefits provided. The strengthening of these regulations will do much to protect students from misdirected community and school enthusiam which occasionally encourages the utilization of an injured player when still unprepared to meet the demands of active competition.

The magnitude of this program and the obvious need for medical guidance are such that the committee's recommendation for continuance of the program for another year has been approved by the Council on Medical Service and Public Relations and the General Council. Publicity concerning the details of the program should be directed to the physicians of the state, and the committee offers its services to handle any complaints which might arise concerning the operation of the program. It is felt by the committee that significant progress has been made this past year, and it is obvious to the committee that officials of the WIAA will welcome the continued counsel of the physician in the further development of the coverage provided children attending the schools of Wisconsin.

Sub-Committee on Nursing

Members: J. R. McGill, chairman; W. C. Andrews; W. H. Studley; W. D. Stovall; K. H. Doege; G. J. Twohig, Sr.

The widely publicized "shortage of nurses" was made the subject of study by the Subcommittee on Nursing after the Council instructed it to survey methods for increasing the number of nurses. At the subcommittee's first meeting in March, it was decided to postpone specific action until the "Murdock Report" of the special American Medical Association Committee on Nursing was made public at the AMA Annual Session, June 21—25. On July, 10, the SubCommittee on Nursing met with representatives of the Wisconsin Conference of Catholic Hospitals, Wisconsin State Nurses Association, Wisconsin Hospital Association, Kenosha and Milwaukee Vocational Schools Attendance Programs, Committee on Nursing Education of the State Board of Health, and The Milwaukee County Hospital School of Nursing.

After a study of the Murdock Report, the joint committee concluded that neither the supply of nurses nor the profession of nursing would be improved by reducing the course of training for professional nurses. The most rapid and satisfactory solution for the nursing shortage at the present time is to be found not in reduction of educational standards or length or method of training of professional nurses, but in increased emphasis on recruitment and training of trained practical nurses.

A survey of the nursing situation in Wisconsin shows that there has been no failure to recruit professional nurses. In fact, more nurses were enrolled and graduated in 1947 than ever before in peacetime. There has been a steady increase in the number of registered nurses in Wisconsin—from 3,074 in 1927 to 10,034 in July 1948. Another 450 nurses now hold emergency permits or are waiting to take examinations. The Murdock Report estimated that

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400,000 nurses will be needed in the United States in 1949, based on a ratio of one nurse to 362 persons in the population. This would mean that Wisconsin should have 8,176 nurses. Today Wisconsin has nearly 10,500 registered nurses. The Committee is quick to point out that although statistics show that Wisconsin is supplied with 20 per cent more nurses than needed, there is still a need for nursing service. This would indicate a study of the utilization of nurses inasmuch as many professional nurses are not engaged in actual nursing care, but unknown numbers are in doctors' offices, industrial nursing, not working at all, or engaged in so-called "luxury care" of patients.

The subcommittee is in agreement that the nursing shortage will be greatly relieved through the training and utilization of trained practical nurses, who, under proper supervision of professional nurses and medical staff, will be able to do much of the routine bedside nursing now being done by professional nurses.

The training program for trained practical nurses is already established and procedure for their licensing perfected. Courses are being offered in Milwaukee and Kenosha Vocational Schools in cooperation with hospitals in both cities. Enrollment, however, has been extremely low as a result of lack of proper publicity and misunderstanding on the part of physicians, lay persons, and potential students.

Several other cities in the state are interested in providing training programs for this type of nurses, but the economic burden on the hospital is often a barrier to establishment of the program. Providing the first three months of training in vocational school partially eliminates this problem. Nurses and hospitals have no objections to practical nurses being trained in the same school as registered nurses, if adequate teaching and clinic facilities are available.

Another factor hindering recruitment of trained practical nurses is that present statutes provide that such schools be known as "schools for nurses attendants" and the graduates as "licensed attendants." The name "trained practical nurse" is agreeable to all parties concerned, and it is recommended that the State Medical Society support legislative efforts to change the statutes to permit "licensed attendants" to be known as "trained practical nurses."

Still another stumbling block toward increased enrollment of trained practical nurses is that no provision is made or credits allowed for advancement from grade of trained practical nurse to the grade of graduate nurse. Your committee recommends that means be found to make such provisions and that the actual decision as to what credits are allowed be made by qualified teaching personnel or the board which does the accrediting and licensing of these individuals.

COMMITTEE ON COORDINATION OF MEDICAL SERVICE

S. B. Harper, chairman; S. E. Gavin; E. F. Tierney; President (ex officio); Secretary (ex officio)

This is a standing committee of the Society acting as a liaison agency with the University of Wisconsin Medical School and the general practicing physician of the state. It was authorized many years ago, and, while problems of considerable importance have been considered by it in meetings with representatives of the medical school, it has seldom been necessary for the group to meet more than once each year.

The pressure of the last war and the problems of medical care and general hospital facilities were such as to place emphasis on matters of other character, but as there has come about a gradual return to the normalcy of practice and patient load, greater consideration has been given to the relationship of the hospital and its teaching facilities to those problems of general concern.

It appears to the committee that there has been a steadily decreasing load of private patient activity, recognizing, however, that various staff members have privileges of the institution for private patient load of somewhat different character than referred cases. Generally, the administration of the institution considers that those with incomes in excess of $3,000 annually should not be considered as other than private pay patients. Nevertheless, the situation is such that Doctor Middleton reports the necessity of using every possible resource for teaching purposes, this being particularly true in the obstetric field. Additions are planned to the hospital which should make more cases properly falling in the teaching category available.

The administration of the institution seems convinced that the hospital should not enter into competitive medical practice, but is, nevertheless, faced with the practical situation of assisting staff members in holding incomes comparable to those in private practice. General discussion has been held with reference to the reporting of cases, the overloading of certain services, and the waiting period involved. Each seems to be about as satisfactory as conditions permit. It has been agreed by the committee that the administration should be invited to submit an annual report through *The Wisconsin Medical Journal* in furtherance of the operational and administrative relations of this institution with those of the medical profession of the state. Your committee recommends this procedure and expresses its belief that in light of all conditions, the existing procedures of the institution represent a practical view of the whole problem.

NOTE FOR DOCTOR

PAGE SPECIAL is a combination of sterilized evaporated milk and fish liver oil concentrate (Barthen). When this milk is reconstituted with an equal amount of water, it contains 2,000 USP units of vitamin A and 400 USP units of vitamin D per quart in addition to milk's normal vitamin content. In terms of USP cod liver oil, this is the vitamin A equivalent of approximately one teaspoonful (2,200 units) and the vitamin D equivalent of one and one-fourth teaspoonsful (315 units per teaspoon). This extra vitamin content is derived exclusively from pure fish liver oil concentrate.

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Society Proceedings

Marathon

Members of the Marathon County Medical Society met at the Hotel Wausau in Wausau on July 27 for a general business session.

Oneida—Vilas

Twenty members and guests attended a dinner meeting of the Oneida–Vilas County Medical Society held July 29 at St. Mary's Hospital in Rhinelander. Following the dinner, Dr. Frederick H. Falls, professor of obstetrics at the University of Illinois College of Medicine, Chicago, presented a paper on "Hemorrhages of Late Pregnancy," illustrating his discussion with lantern slides. "Treatment of the Chronic Alcoholic" was discussed by Mr. Charles B. Lake, president of Ivanhoe Treatment, Inc., of Milwaukee. A general discussion of the lectures followed.

Wood

The Wood County Medical Society held a meeting on August 12 at Wisconsin Rapids. *Dr. E. C. Glenn,* Wisconsin Rapids spoke on the "Recent Trends in the Surgical Treatment of Varicose Veins." A discussion on the present hospitalization program for direct relief patients, primarily from the aspect of the present laws, and presented by Attorney Robert B. L. Murphy, Madison; District Attorney H. A. Bundy of Wood County; and Mr. Harry Precious, Wood County welfare director.

Ninth Councilor District

Physicians from the Ninth Councilor District met at St. Joseph's Hospital in Marshfield for their regular quarterly meeting on July 29. Approximately sixty-five members attended the sessions.

The afternoon meeting consisted of eight round-table discussions pertaining to various fields of medicine.

Following dinner, which was served in the hospital dining room, Dr. F. J. Hirschboeck, of the Duluth Clinic in Duluth, Minn., presented a paper on the "Diagnosis and Problems of Liver Disease." *Dr. E. J. McGinn* of the Marshfield Clinic, Marshfield, spoke on "Retropubic Prostatectomies: A Review of Cases." *Dr. J. F. Gouze,* Marshfield, was in charge of arrangements for the meeting.

Tenth Councilor District

Three Minnesota physicians addressed the meeting of the doctors from the Tenth Councilor District in Eau Claire on September 18. The morning session and luncheon were held at Luther Hospital, and the afternoon session took place at the Eau Claire Country Club. The guest speakers who presented papers were Drs. Walter Fansler, surgeon from Minneapolis; Francis Lynch, dermatologist from St. Paul; and S. B. Lovelady, in the department of obstetrics and gynecology at the Mayo Clinic in Rochester.

News Items and Personals

Dr. R. S. Hirsch Named to Health Board

Dr. R. S. Hirsch, Viroqua, was elected an advisory member of the Vernon County Health Board at a meeting of the group on July 14. This created a five member board instead of the usual four member group as in the past.

Dr. A. J. Klein Opens New Offices

Dr. Alfred J. Klein recently announced the opening of his new offices for the specialized practice of internal medicine in Eau Claire. Doctor Klein is a diplomate of the American Board of Internal Medicine and was formerly assistant professor of medicine at the University of Chicago School of Medicine.

Open Offices and Clinic in Waupun

Drs. Raymond and *Leonard Schrank* opened their new offices and clinic in Waupun on August 2. The new clinic contains four treatment rooms, an x-ray room, dark room, laboratory, and drug room. Complete equipment for x-ray, electrocardiography, metabolism, and laboratory tests and diathermy treatment has been provided.

Dr. C. A. Morrow Opens Practice in Kenosha

Dr. Cecil A. Morrow, a specialist in asthma and hay fever, opened his office in Kenosha on July 29, after several months of study in Cleveland. Doctor Morrow, a graduate of Rush Medical College, will confine his practice to treatment of asthma, hay fever, and allied allergic diseases.

Dr. H. J. Werbel Invited to Join Heart Associations

Dr. Harold J. Werbel, of the staff of the Levin-Delavan Clinic in Dalavan, was recently invited to join the Wisconsin Heart Association and the American Heart Association. Doctor Werbel joined the Levin–Delavan Clinic in May.

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ESTABLISHED 1898

Dr. G. A. Fostvedt Listed in "Men of Science"

The national publication "American Men of Science," which is published every three years, has notified *Dr. G. A. Fostvedt* of the Barron Clinic in Barron that he will be included in the eighth edition of the publication. The book lists medical and scientific men who have made and published outstanding contributions to the progress of medicine or science.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. I. F. Thompson Named Head of State Board of Health

I. F. THOMPSON

Dr. Ira F. Thompson, Beloit, a veteran in the field of public health, was recently elected president of the Wisconsin State Board of Health, to succeed *Dr. Gunnar Gundersen*, La Crosse. *Dr. S. E. Gavin*, Fond du Lac, was named vice-president to succeed Doctor Thompson.

Doctor Thompson retired three years ago and moved to Beloit following fourteen years as city health commissioner at Racine. Prior to that time he worked with the Milbank Health Foundation at Syracuse, N. Y., for seven years.

Dr. F. E. Tryon Retires as City Health Officer

Dr. F. E. Tryon, who has served as health officer of Baraboo for the past twenty-eight years, retired from that position on July 22, under the city's retirement plan. *Dr. K. D. Hannan* has been named successor to the position.

Dr. W. B. Hobbins Working in Chicago

Dr. William B. Hobbins, surgeon who has been associated with the Jackson Clinic in Madison, is now in Chicago, working under the direction of Dr. Karl Meyer, surgeon. While in Chicago, he will be connected with the Cook County Hospital and Northwestern University Medical School.

Dr. A. P. Schoenenberger Enters Practice of Urology

A. P. SCHOENENBERGER

Dr. A. P. Schoenenberger recently became associated in the practice of urology with *Dr. Palmer Kundert*, Madison. Doctor Schoenenberger recently completed a three year residency in the genitourinary department of the State of Wisconsin General Hospital. A graduate of the University of Wisconsin Medical School, the doctor was in private practice at Denmark until 1942, when he entered the Army Medical Corps. He received his discharge in 1945.

Dr. H. M. Coon Attends Workshop

Dr. Harold M. Coon, superintendent of the State of Wisconsin General Hospital, attended a hospital workshop at the Galesburg undergraduate division of the University of Illinois in July.

SOCIETY PROCEEDING

American Interprofessional Institute of Milwaukee

Three Milwaukee physicians spoke before the meeting of the American Interprofessional Institute of Milwaukee at Hotel Pfister on August 2. *Dr. Armand J. Quick* discussed "Recent Advances in Medicine, *Dr. Samuel G. Higgins* explained the "Recent Advances in Surgery of the Eye," and *Dr. W. J. Carson* presented "Recent Advances in Vascular Surgery."

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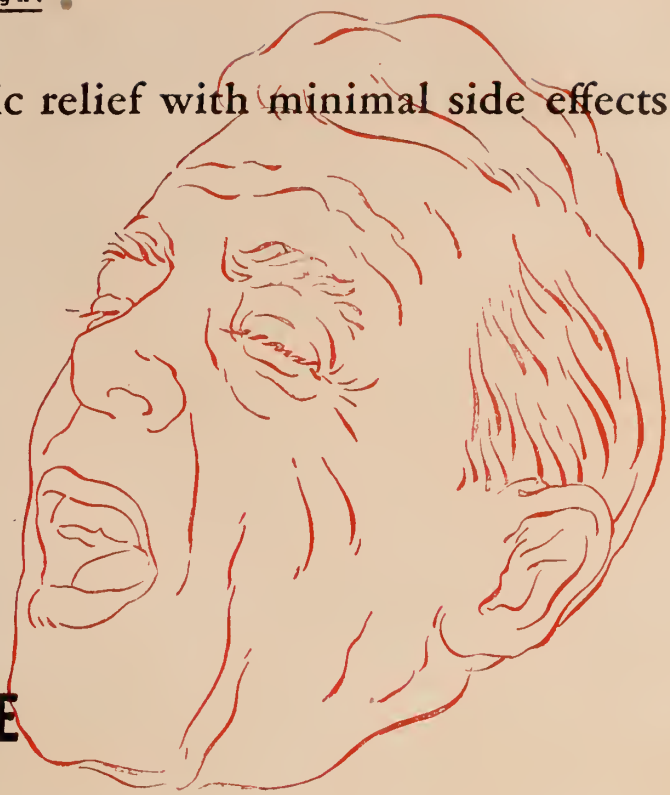

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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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Mark J. Ciccantelli, 228 West Union Avenue, East Troy.

Laird McNeel, Burlington.

Alexander M. Iams, 122 West Washington Avenue, Madison.

Homer P. Baker, Brodhead.

John C. Bennett, 461 Edward Street, Burlington.

Donald T. Hughson, 208 East Wisconsin Avenue, Milwaukee.

Changes in Address

H. E. Wallace, Milwaukee, to 210 East Republic Street, Peoria, Illinois.

H. Gladys Spear, Wauwatosa, to Illinois Neuropsychiatric Institute, Chicago, Illinois.

G. A. Walker, Racine, to % W. H. Gross, RR2, Olathe, Kansas.

R. C. Puestow, Mendota, to Box 223, Lombard, Illinois.

E. H. Federman, Horicon, to Montello.

J. H. Barbour, Madison, to % H. M. Barbour, Ripon.

H. N. Heinz, Milwaukee, to 543 Lower Falls Road, Kohler.

J. J. Furlong, Milwaukee, to 384 Post Street, San Francisco, California.

D. D. Feld, Wauwatosa, to Los Angeles Sanatorium, Duarte, California.

R. C. Heen, Wauwatosa, to 2320 West Mitchell Street, Milwaukee.

J. M. Lynch, Monroe, to 14 Orchard Street, Terryville, Connecticut.

J. A. Flatley, Madison, to Billings Veterans Hospital, Ft. Benjamin Harrison, Indiana.

H. H. Williams, Sr., St. Petersburg, Florida, to 400 East Oak Street, Sparta.

W. G. Rence, Monroe, to Sigaurney, Iowa.

C. P. Giesen, Superior, to Milwaukee County Hospital, Milwaukee.

Elizabeth Grimm, Madison, to Billings Clinic, Billings, Montana.

J. W. Frye, Marshfield, to Columbia Hospital, Milwaukee.

L. W. Keller, Rock Springs, to Brillion.

MARRIAGES

Dr. John T. McCoy and Miss Mary McCormick, Madison, on July 14.

Dr. John C. McCullough and Miss Dorothy Sauter, Fond du Lac, on August 7.

BIRTH

A son to Dr. and Mrs. Frederick G. Joachim, July 27.

DEATHS

Dr. Frederic J. Woodhead, 67, well known Waukesha surgeon and city physician, died August 15 at a Waukesha hospital. He had been in medical practice for forty-one years, twenty-nine of which had been spent in Waukesha.

A native of Waukesha, the doctor was born on January 14, 1881. He was educated at Milwaukee Medical College, now Marquette University School of Medicine, from which he graduated in 1906. He did postgraduate work at the Boston School of Surgery and at the Crile Clinic in Cleveland. His first practice was established at Merton. During World War I he served as a captain in the Army Medical Corps, and, following his discharge in 1919, he located in Waukesha. He was a member of the original board of directors of the Waukesha Memorial Hospital and was staff surgeon at Resthaven during the first ten years after its opening. He had been city physician since 1932.

A member of the Waukesha County Medical Society, the State Medical Society, and the American Medical Association, Doctor Woodhead was also a fellow of the Boston College of Surgeons and a past-president of the D. J. Martin post of the American Legion.

His wife and a son survive.

Dr. Morris W. Sherwood, prominent Milwaukee physician and surgeon, died at a Milwaukee hospital on August 15. He was 57 years old. In active practice in Milwaukee for thirty-five years, he had been city physician for twenty years.

The doctor was born aboard a ship en route from Russia to the United States in 1891. Graduating from George Washington University School of Medicine, Washington, D. C., in 1914, he completed his internship at Milwaukee County Hospital. Shortly afterward he established his practice in Milwaukee. He had been a member of the surgical staff of Mount Sinai Hospital since 1933 and had been chief of staff of the old Milwaukee General Hospital for a number of years. For the past twenty-five years he had also served on the City Safety Commission. During World War II the doctor entered the United States Navy with the rank of lieutenant commander and was stationed as a surgeon in the hospitals in Florida.

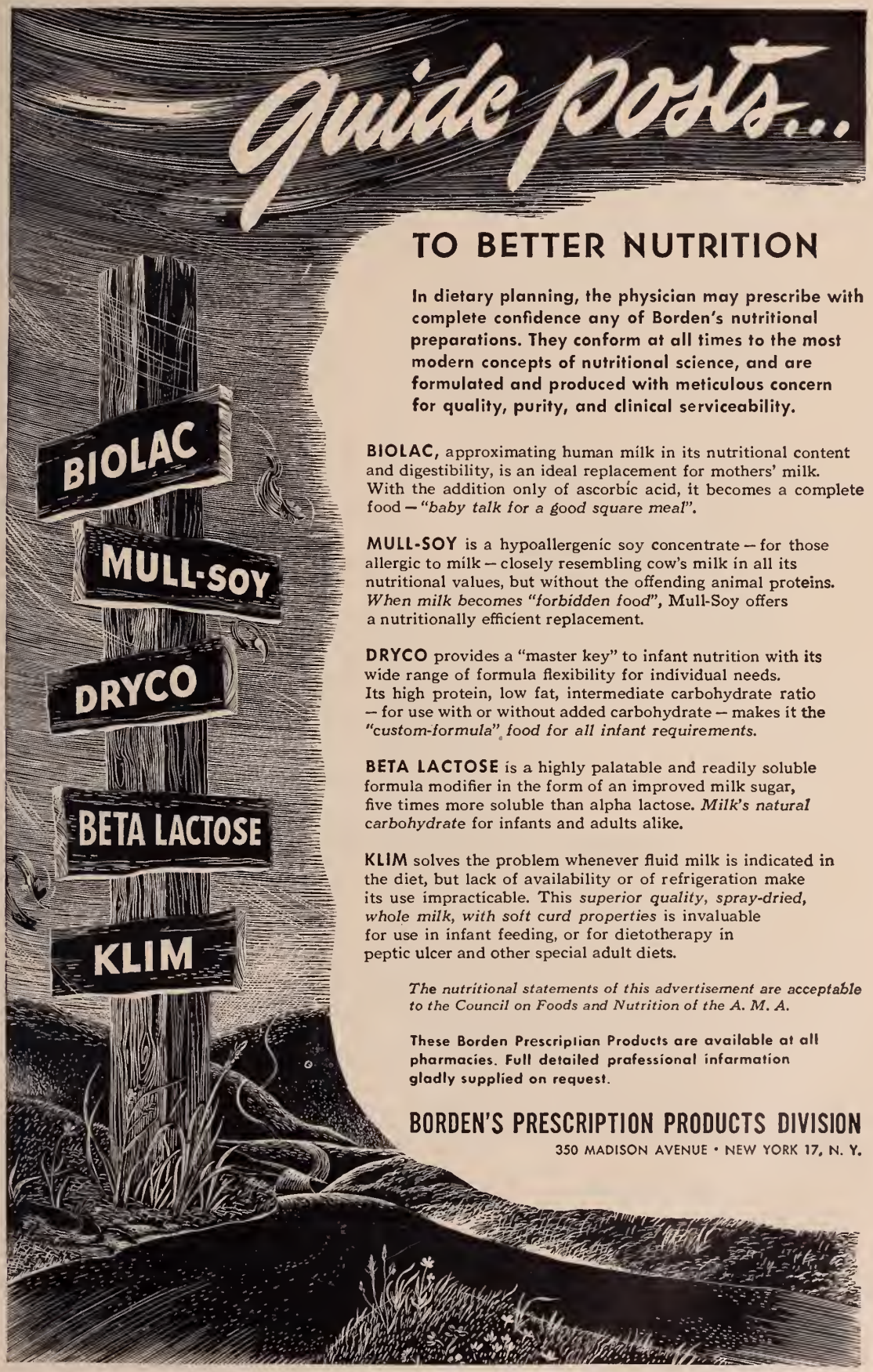
A fellow of the International College of Surgeons, Doctor Sherwood was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his wife, two daughters, and a son.

Dr. Francis M. Chapman, 78, Wisconsin physician for fifty-seven years, died August 14 at a hospital in Milwaukee. He had been in the practice of medicine in Milwaukee for the past forty-five years.

Doctor Chapman was born in Waukesha County on March 28, 1870. He received his medical education at Rush Medical College, Chicago, graduating in 1892.

Survivors include his wife and two daughters.



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Dr. G. E. MacKinnon, widely known physician from Prentice who in 1945 received nationwide acclaim when the people of his community held "Doctor MacKinnon Day," died at a hospital in Tomahawk on August 17. He was 65 years old.

The doctor, born on October 17, 1882, in Seafoam, Nova Scotia, received his medical education at Queen's University Faculty of Medicine in Kingston, Ontario, Canada. Following internship in the Milwaukee Hospital, Milwaukee, he located in Tripoli before moving to Prentice. In 1945, after thirty years of practice in that community, the people of Prentice and the surrounding area honored him on "Doctor MacKinnon Day" and presented him with an automobile, a gold watch, and a purse of money. At this time, *Time, Life,* and *Reader's Digest* and newspapers throughout the country carried articles on the country doctor who had delivered more than 3,500 babies. As a final tribute of their love, his patients are erecting a memorial over his grave, which, in accordance with his request, will bear these three words—"The Country Doctor."

Doctor MacKinnon was a member of the Price–Taylor County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, a daughter, and two sons.

Dr. C. K. Hahn, who practiced medicine in Wisconsin for more than half a century, died at a Racine hospital on August 11. He was 79 years old.

Doctor Hahn was born in Germany on August 16, 1868. Following graduation from the Berlin University Medical School, he came to the United States in 1896. His first practice was established in South Milwaukee, and after a year he moved to Racine, where he practiced for forty-nine years. The doctor retired a year ago. During most of his time in Racine, he was affiliated with the staff of St. Luke's Hospital and at the time of his death he was a member of the hospital's honorary staff.

A member of the Fifty Year Club of the State Medical Society, he held membership in the Racine County Medical Society and the American Medical Association. He also belonged to the Deutscher–Maenner–Verein.

Survivors include a daughter and a son, Dr. Paul Hahn of Racine.

Dr. Clark C. Post, physician at Barron for fifty-three years before his retirement in 1946, died at his home in that community on August 4. He was 81 years old.

The doctor, who was born on May 1, 1867, in Chicago, attended the University of Illinois College of Medicine, receiving his medical degree in 1893. He established his practice in Barron immediately following graduation, and, except for a period of service in the Army Medical Corps in World War I, continued his work in that community until his retirement two years ago. In 1901 his brother-in-law, Dr. H. M. Coleman, became associated with him and together they established the Barron Hospital, which has since developed into the Barron Clinic. Doctor Post had also been surgeon for the Soo Line Railroad for fifty years.

Last year he became a member of the Fifty Year Club of the State Medical Society. He also held membership in the American Legion.

Doctor Post is survived by his wife.

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STATE OF WISCONSIN

No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

Conrad Shearer — Vernon W. Thomson

PRESIDENT PRO TEMPORE OF THE SENATE. SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — Arthur L. May

CHIEF CLERK OF THE SENATE. CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.

For surface infections . . .

Although burned tissues supply an excellent medium for bacterial growth, infection may be minimized by the prompt, topical application of an efficient antibacterial agent. For this purpose, fine-mesh gauze strips impregnated with Furacin Soluble Dressing may be used. The effectiveness of Furacin in combatting mixed infections of burns without delay of healing has been well demonstrated.* Furacin N.N.R., brand of nitrofurazone, is available as Furacin Soluble Dressing and as Furacin Solution, both containing 0.2 per cent Furacin.® These preparations are indicated for topical application *in the prophylaxis and treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: Mil. Surgeon, *97*: 380, 1945. • Shipley, E. R. and Dodd, M. C.: Surg., Gynec. & Obst., *84*: 366, 1947 • Mays, J. L.: J. Med. Assoc. Georgia, *36*: 263, 1947. • Curtis, L.: Surg. Clin. N. America, 1466 (Dec.) 1947.

MEAT...

And the Nutritional Significance of Fat

The all too prevalent practice of trimming the fat from many meat cuts and discarding it not only represents unnecessary economic, but also nutritional, waste. Fat is nutritionally valuable for several reasons, some of them well known, some only recently appreciated.

The fat of meat is an outstanding source of caloric food energy, small in bulk and low in moisture. It carries important fat-soluble vitamins, is well digested and absorbed, and endows the meal with satiety value making for real satisfaction. Meat fat furthermore contains certain unsaturated fatty acids which appear to play a significant and essential part in skin metabolism. Fat also exerts a sparing effect with regard to B complex vitamins.

Recent evidence[1,2] indicates that the presence of fat in a mixed dietary considerably decreases the specific dynamic effect of the three basic nutrients, thus promoting optimal utilization of the protein ingested.

This survey of the nutritional significance of fat again emphasizes the valuable role of meat fat in the daily dietary.

---

[1] Forbes, E. B., and Swift, R. W.: J. Nutrition *27*:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition *31*:203;213 (Feb.) 1946.

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WOMAN'S AUXILIARY

TATE MEDICAL SOCIETY OF WISCONSIN

Mrs. A. W. Hammond
Beaver Dam
President

To EVERY Doctor's Wife:

First of all, let me assure you that the capitalization of EVERY is not a typographical error, but rather an emphatic means of extending a most cordial invitation to the wife of every doctor in Wisconsin, irrespective of affiliation with the Auxiliary, to attend our Annual Meeting, October 3, 4, and 5, at Hotel Schroeder, Milwaukee.

A perusal of the program will convince you that Mrs. Randall and her corps of workers have planned much of great interest and of decided benefit. Relaxing entertainment also has been arranged. In addition, as at all of our conferences, you will find a fine spirit of camaraderie.

But, transcending all these allurements is the main objective of our Auxiliary, namely, the extension of the aims of the American Medical Association into every avenue possible. The doctors, our husbands, have many challenging tasks for us to accomplish. These may be attained by our unanimous efforts.

So you who are eligible, come to be informed and to get acquainted.
And you who are members, come to be better informed and to get better acquainted.

Most sincerely yours,
JANE R. HAMMOND
President

Mrs. A. J. Randall
Kenosha
Convention Chairman

Mrs. M. Q. Howard
Milwaukee
President-Elect

Program

Sunday, October 3, 1948

P. M.

4:00–6:00 Registration—Fifth Floor, Hotel Schroeder

6:00 Board of Directors' Dinner—Club Rooms, Hotel Schroeder

Mrs. A. W. Hammond, president, presiding

Honored Guests: Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin

Reports of state chairmen

Monday, October 4, 1948

A. M.

8:30 Registration and Tickets—Fifth Floor, Hotel Schroeder

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. A. W. Hammond, president, presiding

Invocation—Rev. Richard Cahill, S. J., Pastor of Gesu Church

Pledge of Allegiance to Flag

Auxiliary Pledge

Convention Announcements—Mrs. A. J. Randall, chairman

Address of Welcome—Mrs. L. E. Coffin, president, Woman's Auxiliary to the Kenosha County Medical Society

Response—Mrs. Merle Q. Howard, president-elect, Woman's Auxiliary to the State Medical Society of Wisconsin

In Memoriam—Mrs. L. H. Lokvam, chairman, and Mrs. E. S. Schmidt

Convention Rules and Procedure—Mrs. R. M. Kurten, parliamentarian

Minutes of Annual Meeting, 1947

Reports of State Officers

Reports of County Auxiliary Presidents

Report of Chairman, Committee on Credentials and Registration

P. M.

1:00 Luncheon—Empire Room, Hotel Schroeder

Greetings—Dr. W. D. Stovall, president, State Medical Society of Wisconsin

Style Show—Fashions and models from the Boston Store

7:00 Buffet Supper—Empire Room, Hotel Schroeder

Folk dances and music

Entertainment provided by the State Medical Society of Wisconsin in cooperation with Miss Dorothy Enderis of the Recreation Department, Milwaukee Public Schools

Tuesday, October 5, 1948

A. M.

10:00 General Meeting—Club Rooms, Hotel Schroeder

Mrs. A. W. Hammond, president, presiding

Business Session

Election of Officers

Induction of the President, Mrs. Merle Q. Howard

Installation of New Officers

Announcements

Report of Chairman of Committee on Credentials and Registration

11:30 Post-Convention Meeting, Board of Directors—Club Rooms, Hotel Schroeder

Mrs. Merle Q. Howard, president, presiding

P. M.

1:00 Luncheon—Banquet Room, Hotel Schroeder

Interior Decorating Demonstration by Mr. Harold Schack of Schuster and Company, Inc.

6:45 Informal Banquet, State Medical Society of Wisconsin—Crystal Ballroom, Hotel Schroeder

State Officers

President	Mrs. A. W. Hammond, Beaver Dam
President-Elect	Mrs. Merle Q. Howard, Milwaukee
Vice-President	Mrs. N. A. Hill, Madison
Recording Secretary	Mrs. E. J. Schneller, Racine
Corresponding Secretary	Mrs. E. P. Webb, Beaver Dam
Treasurer	Mrs. J. P. Graves, Kenosha
Parliamentarian	Mrs. R. M. Kurten, Racine

Delegates and Alternate Delegates to the Twentieth Annual Meeting of Woman's Auxiliary to the State Medical Society of Wisconsin*

County	President	Alternate to President	Delegate	Alternate Delegate
	Mesdames	*Mesdames*	*Mesdames*	*Mesdames*
Ashland–Bayfield–Iron	J. W. Prentice	W. J. Tucker	F. D. Weeks	None
Barron–Washburn–Sawyer–Burnett				
Brown–Kewaunee–Door	J. E. Halloin	R. W. Burns	Louis Milson	G. F. Denys
Columbia–Marquette–Adams	C. F. Cheli	None	J. J. Saxe	None
Crawford				
Dane	D. L. Williams	C. F. Schroeder	C. K. Schubert	L. R. Cole
			E. P. Roemer	Lester McGary
Dodge	R. F. Schoen	C. L. Qualls	M. M. Temkin	G. H. C. Hoyer
Douglas	R. P. Fruehauf	H. B. Christianson	H. A. Sincock	T. J. Doyle
Fond du Lac	E. V. Smith, Jr.	L. J. Simon	R. W. Steube	J. W. Connell
Kenosha	L. E. Coffin	J. B. Pearson	A. M. Rauch	C. M. Creswell
La Crosse	Perry Walters	P. C. Gatterdam	F. H. Wolf	G. B. Ridout
Marinette–Florence				
Milwaukee	S. K. Pollack	B. P. Churchill	R. D. Champney	C. D. Partridge
			L. T. Servis	J. J. Adamkiewicz
			Maurice Hardgrove	L. J. Van Hecke
			W. F. Grotjan	J. J. Pink
			F. J. Kozina	H. R. Foerster
			Charles Fidler	E. P. Bickler
			W. H. Studley	M. J. Reuter
			N. W. Bourne	I. I. Cash
Outagamie	A. J. Gloss	G. L. Boyd, Sr.	F. M. Hauch	A. C. Taylor
Polk	V. C. Kremser	R. G. Arveson	L. O. Simenstad	G. B. Noyes
Racine	R. H. Lehner	K. C. Kehl	J. M. Albino	H. J. Barina
Sauk	J. J. Rouse	C. R. Pearson		
Sheboygan	J. W. McRoberts	P. B. Mason	L. M. Simonson	H. H. Kohler
Walworth	H. J. Kenney	J. D. Warrick	C. Y. Wiswell	E. D. Sorenson
Washington–Ozaukee	E. L. Bernhardt	A. H. Barr	R. G. Edwards	R. S. Fisher
Waukesha	W. D. James	Gwilym Davies	F. L. Grover	F. W. Aplin
Winnebago	R. C. Brown	R. H. Bitter	F. H. Smith	R. F. Wagner

* Listing incomplete. Names of delegates not submitted.

Committees

Executive Committee

Mrs. A. J. Randall, chairman
Mrs. E. F. Andre, co-chairman
Mrs. L. E. Coffin, co-chairman
Mrs. R. M. Block, program chairman
Mrs. C. C. Davin, brochure chairman

Registration and Credentials

Mrs. J. B. Pearson, chairman
Mrs. Charles Ulrich, co-chairman
Mrs. J. S. Altman
Mrs. J. P. Graves
Mrs. A. M. Rauch
Mrs. E. F. Andre

Publicity

Mrs. W. H. Studley, chairman
Mrs. N. W. Bourne

Convention Hall

Mrs. W. F. Grotjan

Program

Mrs. R. M. Block, chairman
Mrs. J. J. Lutz
Mrs. P. E. Pifer

Brochure

Mrs. C. C. Davin, chairman
Mrs. C. M. Creswell
Mrs. G. C. Schulte
Mrs. W. C. Kleinpell
Mrs. Theodore Sokow
Mrs. N. A. Hill
Mrs. W. H. Lipman

House

Mrs. W. C. Liefert, chairman

Convention Hostesses

Mrs. C. G. Richards, chairman
Mrs. A. L. Mayfield, co-chairman

Flowers

Mrs. B. S. Hill
Mrs. C. M. Creswell
Mrs. H. C. Kappus

Board of Directors' Dinner

Mrs. H. J. Heeb, chairman

Hostesses

Mrs. L. H. Lokvam
Miss Norabelle Binnie
Mrs. L. T. Kent
Mrs. S. K. Pollack

Luncheon Meeting, October 4

Mrs. Alexander Schlapik, chairman
Mrs. H. M. Ripley, co-chairman

Hostesses

Mrs. Robert McDonald
Mrs. J. L. Garvey
Mrs. H. L. Schwartz
Mrs. A. F. Rufflo
Mrs. Morris Siegel
Mrs. L. H. Creighton

Buffet Supper, Monday, October 4

Mrs. W. H. Lipman, chairman
Mrs. W. C. Kleinpell, co-chairman

Hostesses

Mrs. G. C. Schulte
Mrs. R. W. Ashley
Mrs. P. E. Pifer
Mrs. R. M. Block
Mrs. D. N. Goldstein

Luncheon, Tuesday, October 5

Mrs. Charles Ulrich, chairman
Mrs. J. S. Altman, co-chairman

Hostesses

Mrs. William Germain
Mrs. Dexter Witte
Mrs. W. C. Stewart
Mrs. W. W. Little
Mrs. F. S. De Fazio
Mrs. Leonard Rauen
Mrs. L. E. Coffin

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THE JOURNAL BOOKSHELF

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

A Text-Book of Pathology. By E. T. Bell, M. D., Professor of Pathology, University of Minnesota, Minneapolis, with contributions by B. J. Clawson, M. D., Professor of Pathology, and J. S. McCartney, M. D., Associate Professor of Pathology, University of Minnesota. Sixth edition, thoroughly revised. Pp. 910, with 500 engravings and 4 color plates. Philadelphia: Lea & Febiger, 1947. Cloth. $10.00.

Pathology has been classified by J. R. Baker as an eclectic science, because it draws upon two or more basic sciences to facilitate study of its field of investigation. Whilst this is substantially true of what is called experimental pathology, it omits the large vista of the natural history of this science, which comprises the bulk of its facts and data. Bell's book has arrived at a sixth edition, with emphasis commendably put upon the natural history of the phenomena of disease. Whilst there are numerous examples of this attitude throughout the text, perhaps the most salient is in the author's regard for tumors. In his discussion of malignancy, he enumerates the customary criteria, and then drops a dictum, which approximates to an aphorism and which is undoubtedly the sum of a wisdom begotten of wide experience with the natural histories of neoplasia. A wealth of knowledge has entered into the statement that "A tumor is as malignant as its most malignant part; malignancy should not be judged by the average structure." By this and similar polities the sixth edition is rendered as praiseworthy as its predecessors.

It is, however, not faultness and free of controversial issues, for it is possible to differ with the author on two points of fact and two of opinion. To categorically state that homologous serum jaundice is produced by parenteral injection of volunteers but not by oral administration is contrary to the findings of Bradley in England, who used both routes successfully for transmission of the disease to patients with rheumatoid arthritis. Furthermore, the independence of homologous serum jaundice and epidemic hepatitis is not proved by the negative rationalization that an attack of one variety does not prevent the other. Findlay's studies on the immunology, with liver brei from a case of epidemic hepatitis, revealed no significant difference in the complement-fixing antibodies.

On the other hand, the view that in portal cirrhosis "the development of the collateral circulation may be so complete that no ascites develops" appears to beg the question, for the criterion of adequate collateral circulation is given as the prevention of ascites. This would be well, however, if it did not happen that ascites still develops in instances when the collateral channels are fully opened, such as in the Cruveilhier–Baumgarten syndrome. Furthermore, completeness of collateral circulation may not signify adequacy in all cases, especially when other factors such as lower serum proteins and infection predispose to edema.

There is one final issue which has fostered contention. This is the etiology of calcific sclerosis of the aortic valve. Monckeberg, when he originally described it, attributed it to degenerative processes. Since then others, including Karsner and the author of the present text, have stated the cause to be rheumatic. The recent careful study by Ashworth has implemented the view that many cases are degenerative and arteriosclerotic, although he does not deny a rheumatic origin is probable in other cases. This middle course perhaps approaches the truth. It is unfortunate nevertheless that the view expressed succinctly by Bell in fourteen lines is not counterbalanced by even a line concerning the opposite opinion, which is repudiated with almost emotional vigor.—J.W.H.

The Head, Neck and Trunk; Muscles and Motor Points. By Daniel P. Quiring, Ph. D., Head of the Anatomy Division, Cleveland Clinic Foundation, and Associate Professor of Biology, Western Reserve University, Cleveland. Pp. 115, with 103 illustrations. Philadelphia: Lea & Febiger, 1947. Price $2.75.

This book is designed as a companion volume to "The Extremities." Its purpose is to portray in diagrams and condensed descriptions the individual

muscles of the head, neck, and trunk, together with their chief arterial and nerve supply. The diagrams are based upon original dissections and upon references to the anatomic literature. Page references to Gray's "Anatomy," twenty-fourth edition, and to Cunningham's "Anatomy," eighth edition, are given. The muscles of the left side have been shown throughout. Since the trunk and deeper neck muscles do not lend themselves to accurate electrical testing, only the general motor points of the face and neck are shown in a single figure.

Each page presents a black and white outline of the skeletal parts and shows a single muscle with its nerve and blood supply. Beneath each figure are given in outline form: origin, insertion, function, nerve, artery, and references.—F.D.G.

A Textbook of Medicine. Edited by Russell L. Cecil, A. B., M. D., Sc. D., Professor of Clinical Medicine, Cornell University Medical College; Consulting Physician, New York and Veterans' Hospitals; Visiting Physician, Bellevue Hospital, New York City. With assistance of Walsh McDermott, M. D., Associate Professor of Medicine, Cornell University Medical College. Associate Editor for Diseases of the Nervous System: Harold G. Wolff, M. D., Associate Professor of Neurology, Cornell University Medical College. Seventh Edition. Pp. 1730, with 244 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price $10.00.

To review a physiologic, pathologic, clinical, and therapeutic medical text as is ours in the seventh edition of Cecil's "Textbook of Medicine," is to comment on the entire field of medical endeavor as well as surgical problems which arise, for in this edition new concepts are combined with the old, new physiologic approaches are added to older established and proved dictums. Throughout, the basic principles of the practice of the art of medicine are maintained.

As Doctor Cecil states in the preface, this colossus of medical knowledge becomes even more noteworthy because of the fact that many of the contributors were overseas in the armed forces at the time that their contributions had to meet the publisher's deadline and our vast libraries and laboratories were not available to them. Nonetheless, by added work and correspondence the compilation of the new treatises and revision of previously existing chapters was achieved. Especially noteworthy additions are the chapters on vitamins by Tom D. Spies, Cecil Watson's discussion of porphyria, and Harold G. Wolff's section on headaches. Naturally, Franklin M. Hanger's contribution on jaundice leaves little to be desired. His clear and concise treatment of etiology and pathologic physiology brings up-to-date many of the current concepts on liver disease. This reviewer is glad to see a section on psychosomatic medicine, which, of course, can only graze the surface in the limited space, but shows a step in the right direction by its inclusion.

The list of new authors reads like a Who's Who of Medicine and includes Frank L. Horsfall, Jr. (virus diseases), Charles A. Janeway (lymphocytic choriomeningitis), Wesley W. Spink (streptococcal infections), John A. Toomey (diphtheria), Thomas

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P. Almy (amebiosis), Arthur J. Patek, Jr., (liver disease), David P. Barr (diseases of the thyroid) and many others. Robert Loeb's section on diabetes mellitus is a valuable monograph in itself. There have been many changes in the section on diseases of the nervous system, edited by Harold G. Wolff, and such men as A. T. Milhorat, H. Houston Merritt, and Robert Wartenberg are new contributors.

The popular two column format of the sixth edition is retained, and several excellent color plates have been added. The completeness of this seventh edition makes it one of the best medical texts of all time, and it is recommended highly to students who are learning for the first time, to teachers who desire clear and workable outlines, and to busy practitioners who want easily available and relatively thorough reviews on almost any medical subject. —F. W. VK.

Surgical Pathology. By William Boyd, M. D., Dipl. Psychiat., M. R. C. P. Edin., F. R. C. P. Lond., LL. D. Sask.. M. D. Oslo, F. R. S. C., Professor of Pathology, The University of Toronto, Canada. Sixth edition. Pp. 858, with 530 illustrations, including 22 color figures. Philadelphia and London: W. B. Saunders Company, 1947. Price $10.00.

This well known book, now in its sixth edition, remains a leader in its field, being strengthened by minor as well as major additions in many chapters, New material includes a section on the pathology and pathologic physiology of congenital heart conditions, as well as discussions on various subjects, such as tumors of the larynx pinealoma, fibrous displasia of bone, inflammatory nodules of muscle in chronic arthritis, fibrositis of the back, avitaminosis in cancer of the mouth, enterogenous cysts, the effect of thiouracil on the thyroid, atrophic gastritis and its relation to ulcer development, the relation of gastric ulcer to the development of gastric carcinoma, the Papanicolaou vaginal smear method in diagnosing carcinoma of the cervix, etc.

Several minor items have been omitted from this edition without detracting from the excellence of the work. Certain subjects, such as hydronephrosis, have been rewritten in part.—W. H. J.

A Hand-Book of Ocular Therapeutics. By the late Sanford R. Gifford, M. D., F. A. C. S., Professor of Ophthalmology, Northwestern University Medical School, Chicago, Illinois. Revised by Derrick Vail, M. D., D. O. (Oxon.) F. A. C. S., Professor of Ophthalmology, Northwestern University Medical School, Chicago, Illinois. Fourth edition, thoroughly revised. Pp. 336, with 66 illustrations. Philadelphia: Lea & Febiger, 1947. Price $5.00.

The fourth edition of Gifford's "A Hand-Book of Ocular Therapeutics" as revised by Derrick Vail, M. D. has been extensively rewritten. Many changes were necessitated by rapid strides made in ocular therapeutics during the past four years. The first five chapters are devoted to therapeutic agents, their actions and uses; the remaining eleven chapters describe specific eye diseases and the author's methods of treatment. The chapter on disorders of

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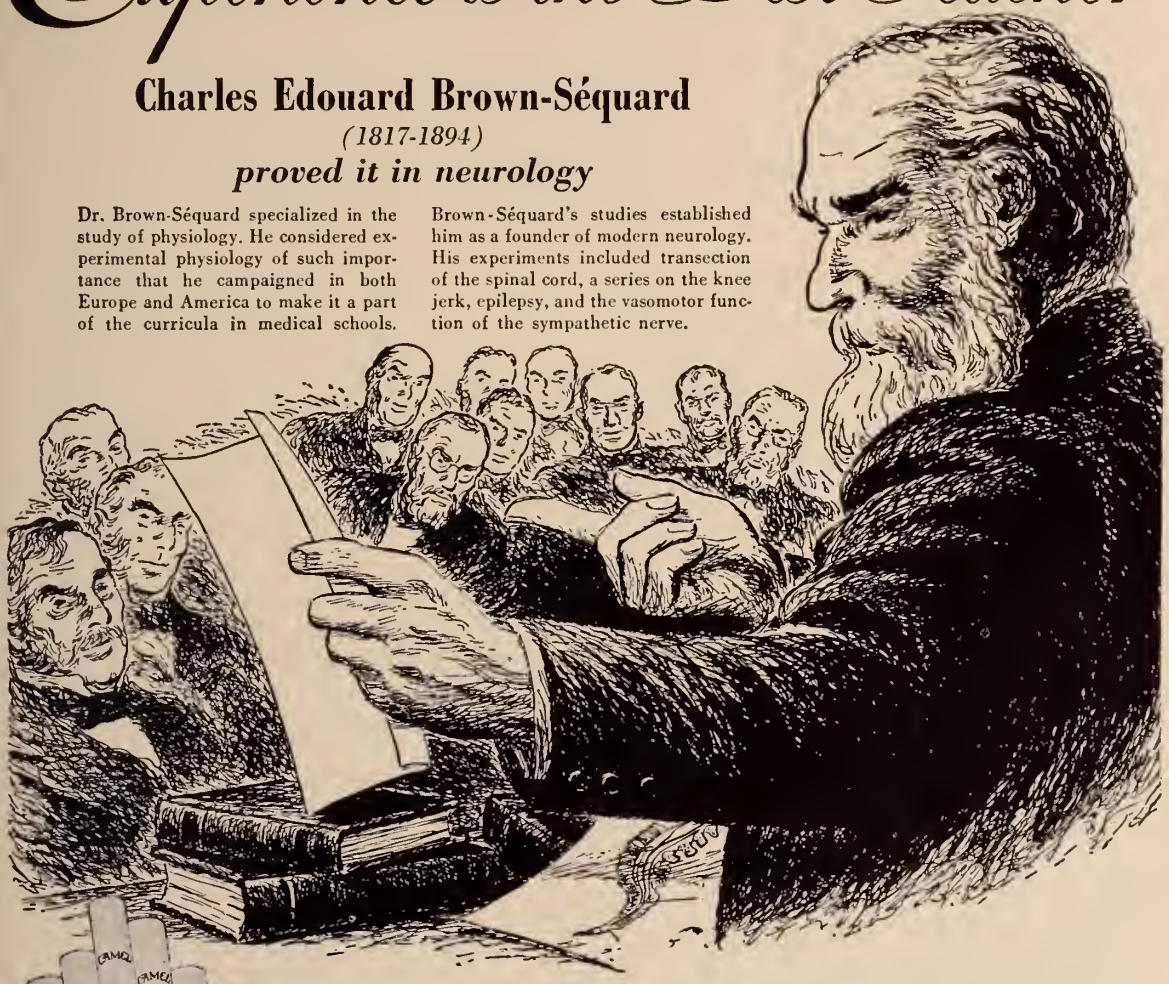

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Contributors to the fourth edition include Dr. F. C. Cordes of San Francisco and Dr. John P. Bellows of Chicago.

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Taking the Cure; the Patient's Approach to Tuberculosis. By Robert G. Lovell, M. D., University Hospital, University of Michigan, Ann Arbor, Michigan. Pp. 93. New York: The Macmillan Company, 1948. Price: $2.00.

This book attempts to give the patient with tuberculosis the correct attitude towards the problems of such a disease. For the most part the suggestions are simple enough for the patient to grasp. Discussion of the disease and the methods of treatment is general enough that it will not cause the patients concern if their own physicians' approach varies from that of this text.

The book could be given to any patient with tuberculosis without any reluctance. Just how much of this advice will be adopted by the patients is questionable. Unfortunately the problems of the tuberculosis individuals can not be solved by any physician who is responsible for their welfare by merely thrusting this book in their outstretched hands. However, this is no criticism of this book, which is one of the better ones of its field.—H. A. D.

Psychiatry for the Pediatrician. By Hale F. Shirley, M. D., Associate Professor of Pediatrics and Psychiatry, Executive Director of the Child Psychiatry Unit. Stanford University School of Medicine. New York: The Commonwealth Fund, 1948. Price $4.50.

Although primarily intended for medical students, interns, and residents, this book should be studied by every physician whose work brings him in contact with children. The first section, "Basic Concepts in Child Guidance," sets forth the child's fundamental needs for security and satisfactions and is almost a complete text in itself. The other sections relate these basic needs to habit training, to intellectual factors, to emotional factors, etc. The final two chapters give a general picture of methods of investigation and treatment which give the nonpsychiatrist a good picture of how the psychiatrist works.—H. K. T.

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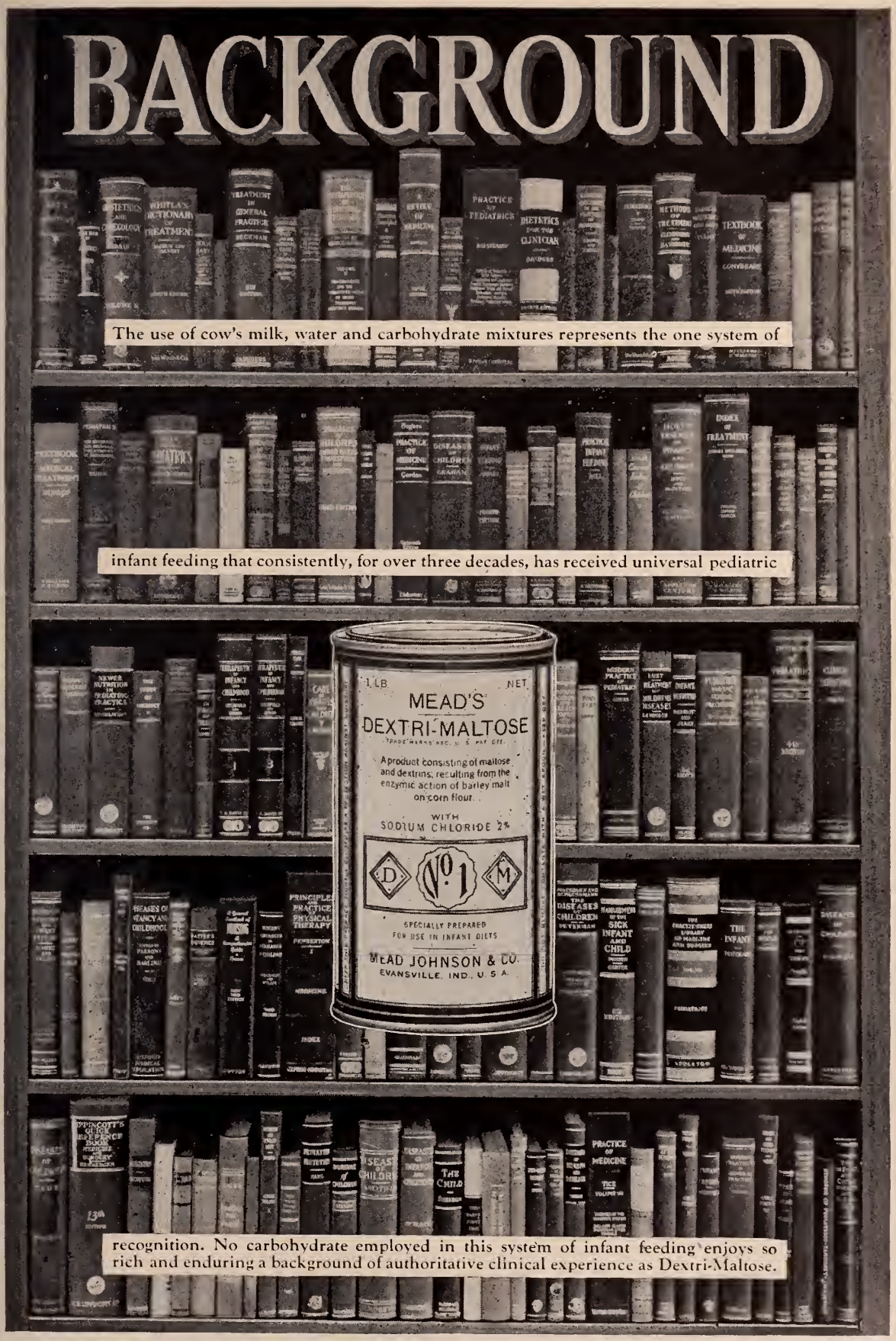
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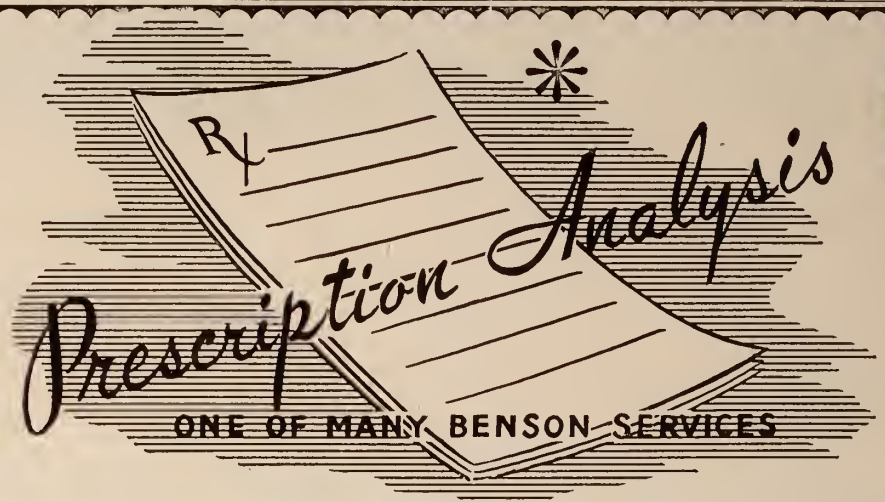

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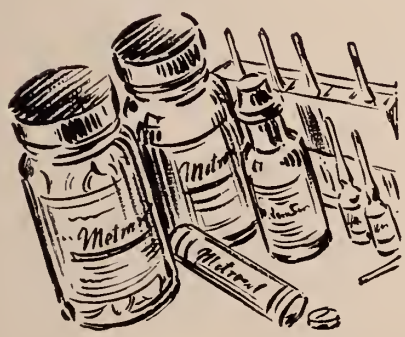

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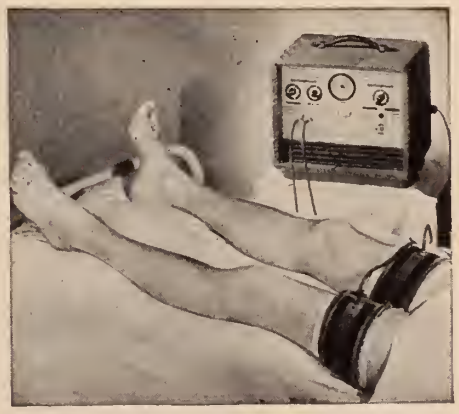

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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	845
Ahlstrom Surgical Company	840
American Meat Institute	942
Ames Company, Inc.	964
Audiphone Utilities	963
Ayerst, McKenna & Harrison, Ltd.	843
Barlow–Maney Laboratories	850
Barr X-Ray Company	958
Bellevue Place	961
Benson Optical Company	956
Bergmann Prescription Center	954
Bilhuber–Knoll Corporation	957
Borden Company	937
Camel Cigarettes	951
Camp, S. H. and Company	955
Central Drug	952
Ciba	935
Continental Casualty Company	954
Cook County Graduate School of Medicine	959
Doerflingers	961
Eaton	941
Endocrine Laboratories	959
First Central Dispensary	954
Hotel Schroeder	961
House of Bidwell	958
Hurley X-Ray Company	963
Ivanhoe Treatment, Inc.	938
Jensen Brothers Prescriptions	952
Kennedy–Mansfield	962
Lilly, Eli and Company	facing page 855
Lov-é Brassieres	848
Luzier's Cosmetics, Inc.	852
M & R Dietetic Laboratories	947
Mallatt Pharmacy	954
Mather Pharmacy	952
Mayer Drug	952
Mead Johnson and Company	953, 966
Medical Protective Company	846
Michael Reese Hospital	949
Milwaukee Optical Company	841
Milwaukee Sanitarium	968
National Drug Company	842
New World Life Insurance Company	958
New York Polyclinic	958
Orthopedic Appliance Company	963
Page Milk Company	931
Parke Davis and Company	838, 839
Philip Morris	844
Physicians and Hospitals Supply Co.	853
Physicians Casualty Association	961
Physicians Radium Association	963
Pogue, Mary E. School	963
Prescription Pharmacy	954
Professional Business Service	*Forum* 5
Radium Emanation Corporation	933
Radium Service Corporation	961
Rennebohms	954
Rentschlers	962
Rexair	967
Riggs Optical Company	959
Rogers Memorial Sanitarium	968
Sacred Heart Sanitarium	957
St. Croixdale Sanitarium	841
Schering	847
Schlintz Bros. Drug Store	952
Searle, G. D. and Company	927
Shorewood Hospital Sanitarium	933
Squibb	849
Summit Hospital Sanitarium	950
Time Insurance Company	*Forum* 3
Upjohn	939
Winthrop–Stearns, Inc.	854
White Laboratories, Inc.	851
Wyeth	929

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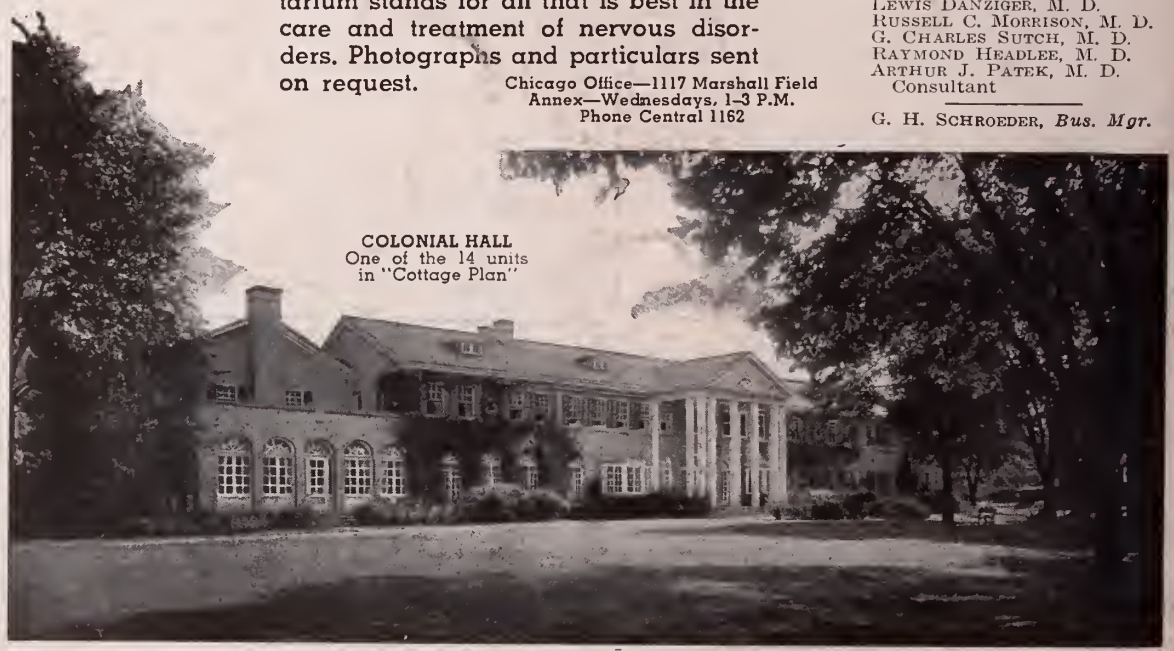

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(1) Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: Am. J. Dis. Child. 61:1 (July) 1943.

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TABLE OF CONTENTS

Page

SCIENTIFIC ARTICLES

Evaluation of the Cardiac Patient for Anesthesia and Surgical Procedures, by Ovid O. Meyer, M. D., Madison ---------- 987

Evaluation and Management of the Cardiac Patient for Anesthesia and Surgery, by Francis F. Rosenbaum, M. D., Milwaukee ---------- 989

Duodenal Diverticula, by J. W. McRoberts, M. D., Sheboygan ---------- 994

Antibiotics in Ear, Nose, and Throat, by Samuel Salinger, M. D., F. A. C. S., Chicago ---------- 997

A Symposium on Prolonged Labor, by James H. Bloomfield, M. D., Chicago ---------- 999

Comments on Treatment ---------- 1002

Notes on Clinical Pathology ---------- 1010

As It Looks to Your State Board of Health ----- 1011

EDITORIALS

Health and Peace, by Brock Chisholm, M. D. -- 1017

Antivivisectionists Exposed ---------- 1018

Medicine as a World Problem, by Morris Fishbein, M. D. ---------- 1019

Page

MISCELLANY

The WIAA Program ---------- 1003
Schedule of Benefits ---------- 1004
Medical Regulations ---------- 1005
Conditions of Payment ---------- 1006
Simplified Reporting ---------- 1007
Parents Told About WIAA ---------- 1009
The New President ---------- 1013
As It Looks from the County Judge's Office ------ 1014
Minutes of the Council Meeting, Hudson, May 15 and 16, 1948 ---------- 1021
Recent Wisconsin Licentiates ---------- 1024
Society Proceedings ---------- 1028
News Items and Personals ---------- 1030
And About the Third and Twelfth Districts ---- 1030
Society Records ---------- 1032
Marriages ---------- 1034
Deaths ---------- 1034
The Woman's Auxiliary ---------- 1036
The Journal Bookshelf ---------- 1042
Coming Events ---------- 1048
Trade News ---------- 1052
Index to Advertisers ---------- 1054
Physicians' Exchange ---------- 1056
List of Executive Officers of County Medical Societies ---------- 1057

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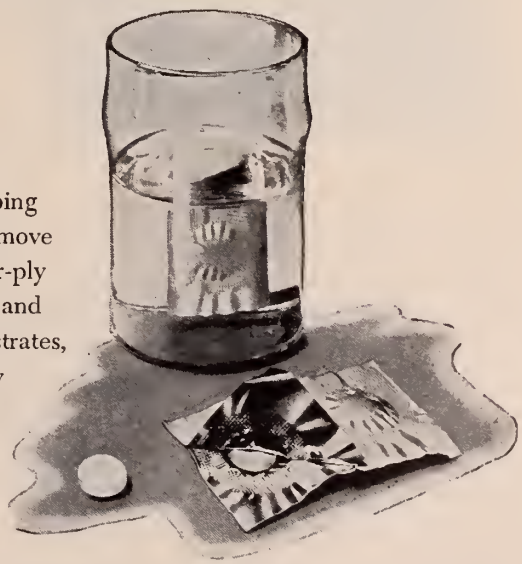

1. Hoffman, W. S., and Volini, I. F.: Am. J. M. Sc. 213:520 (May) 1947

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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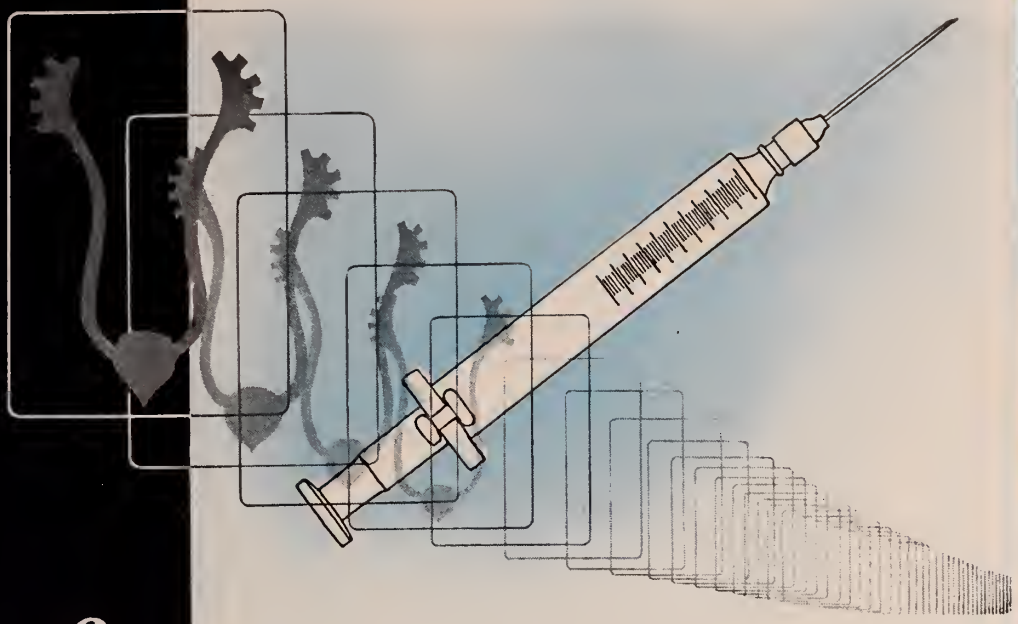

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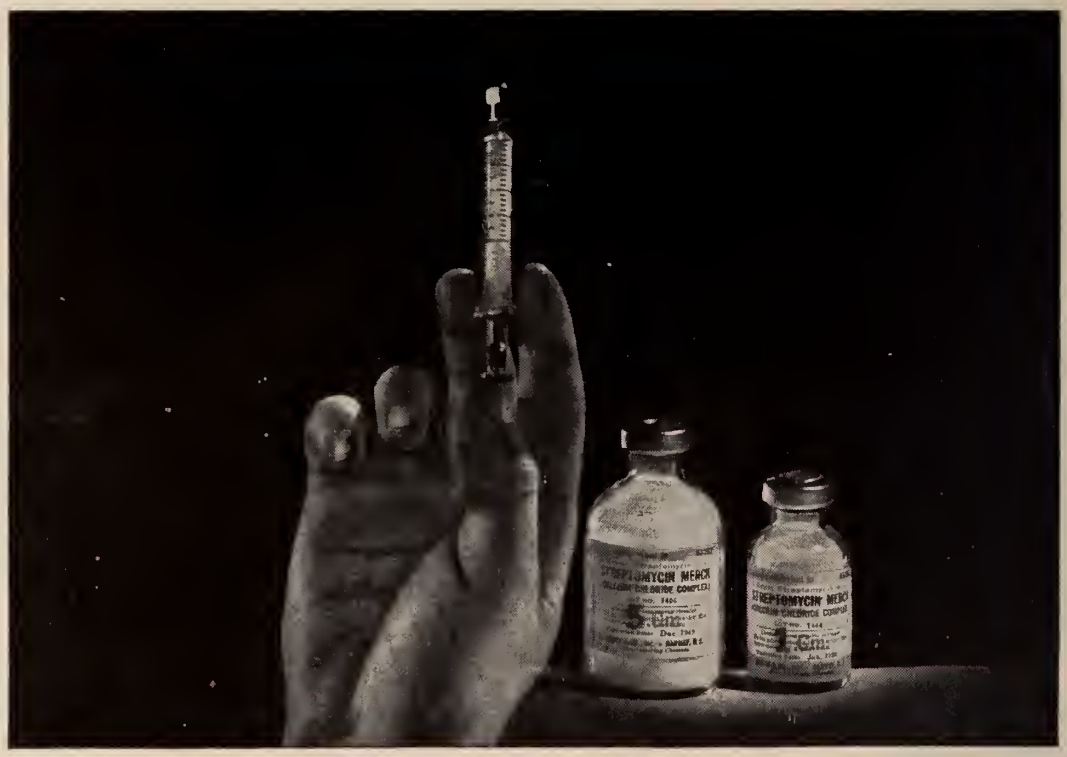

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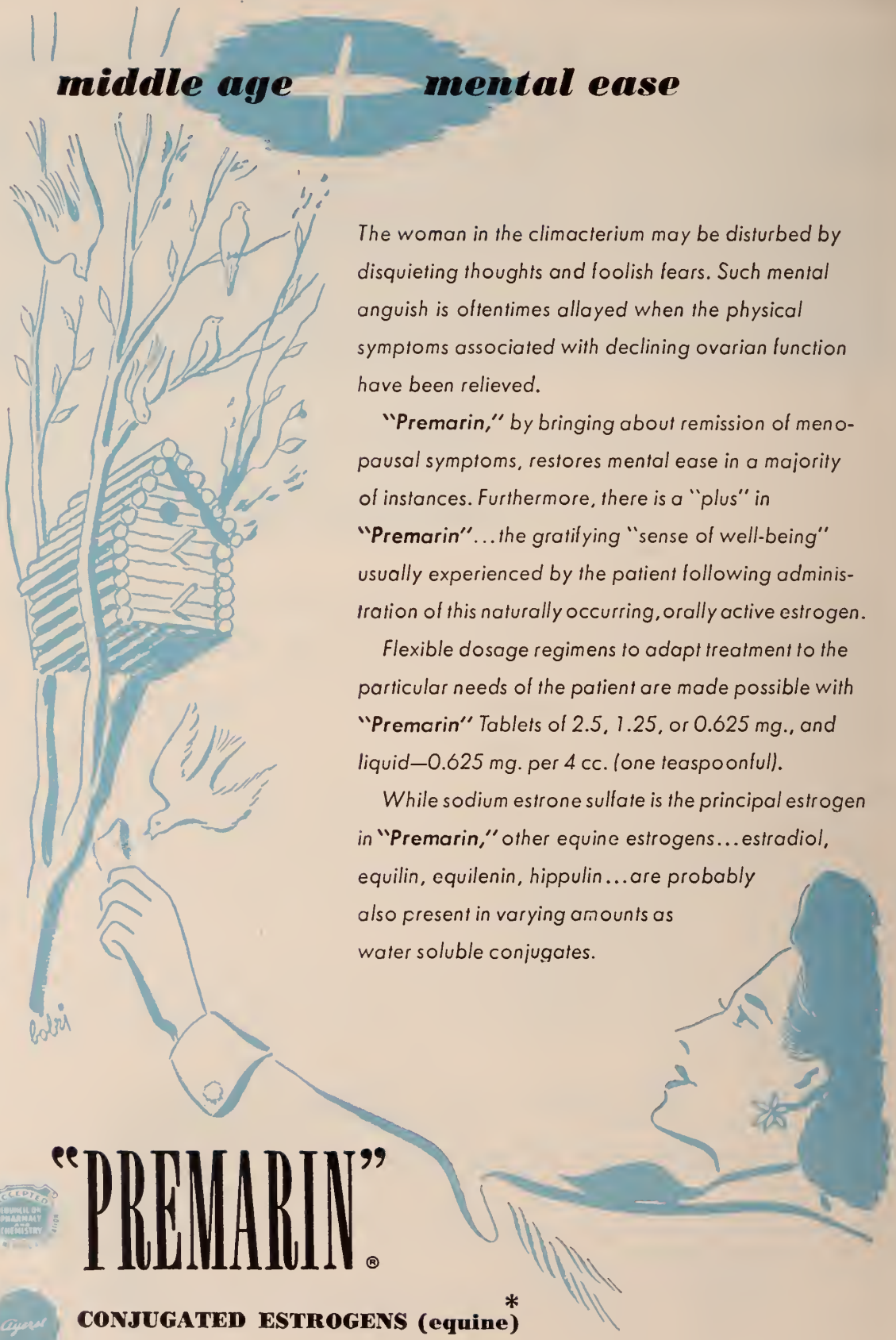

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THE WISCONSIN MEDICAL JOURNAL

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Evaluation of the Cardiac Patient for Anesthesia and Surgical Procedures*

By OVID O. MEYER, M. D.
Madison

Introduction

OPERATIONS upon cardiac patients need not be feared as much as is generally supposed, for in the main they withstand even severe surgical procedures surprisingly well, whatever the stage of the cardiac abnormality, if proper measures are taken to insure compensation. Occasionally, however, careful evaluation of the several factors in the situation may be extremely important, even crucial.

When an operation on a cardiac patient is being considered, two questions arise at the outset. The first, of course, is the accuracy of the diagnosis calling for surgical treatment, opportunities for error being as numerous as they are. For our purposes here we need not elaborate this point: we shall assume that the diagnosis is correct and that the symptoms which indicate the need for surgical procedures are not themselves attributable to the heart disease. The surgical correction of congenital heart abnormalities is, of course, a highly specialized field in itself, with which this paper is not concerned. There, one may say in passing, the accurate anatomic diagnosis and evaluation of the patient's condition are obviously of supreme importance.

The second question is whether in the face of the existent cardiac condition the surgical procedure is justifiable. It would certainly be unwise to perform a thyroidectomy for cosmetic reasons alone on a patient suffering from cardiac asthma with which the prognosis is for less than two years' life expectancy. However, one would usually be justified in operating for acute intestinal obstruction in the face of serious hypertensive cardiovascular disease, whereas the repair of a cystocele for this same patient might seem unwise.

Anesthesia

When the decision is finally made to perform an operation, elective or mandatory, on a patient afflicted with some form of heart disease, the physician can help to assess the extent to which the cardiac abnormality increases the risk and offer his assistance in overcoming that risk so far as possible. The problem calls for close cooperation between the surgeon, the anesthetist, and the physician. And it may be repeated here that when an operation presents such a problem, it is more important, as Marvin has said,[1] to select the proper anesthetist than the particular anesthetic agent to be administered. Dr. Ralph Waters agrees with Marvin's statement. The inexperienced anesthetist should use the anesthetic agent which he handles best. It is true, as we demonstrated almost twenty years ago,[2] that general anesthesia produces a persistent elevation of the venous pressure, which suggests an added strain on the right ventricle; but this does not necessarily mean that the hazard is seriously increased.

The problem of heart disease in the surgical patient has not been subjected to a great deal of organized research, but a number of investigators have been interested, notably, Marvin,[1] Levine,[3] Sprague,[4] Purks,[5] Scherf and Boyd,[6] and Brow and Long.[7]

Causes of Death

The most common causes of the postoperative death of cardiac patients are congestive heart failure, coronary occlusion, and cerebral accidents; the latter occur most frequently, as one would expect, in patients with hypertension and arteriosclerosis. Pulmonary embolism is decidedly more common postoperatively in the cardiac patient, probably for two reasons: the slowing of the blood flow in the decompensated heart, with resultant tendency toward venous thrombosis, and, secondly, the occurrence of auricular thrombi in fibrillating auricles. Carlotti *et al.*[8] have just reported the decidedly greater incidence of the former basis. They also found that pulmonary embolism was much more common in medical cases than in surgical cases. Purks[5] found that the cardiac group he studied differed from his noncardiac group chiefly in the occurrence of fatal coronary occlusion and in the greater incidence of fatal pulmonary complications, chiefly infection and pulmonary embolism.

The Electrocardiogram

The changes in the electrocardiogram during operation and anesthesia are largely of a minor character and have no great influence upon the circula-

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

tion. They are of physiologic rather than clinical importance. [9, 10] The importance of the electrocardiogram in the preoperative study of the cardiac patient is not to be minimized, however; especially is that so in patients over 50.

Mortality Rates

Butler, Feeney, and Levine,[11] who reviewed the cases of 414 patients suffering from organic heart disease at the time they underwent various major surgical operations, found that only 6.4 per cent died unexpectedly and that, moreover, the complications resulting in death were the same as with noncardiac patients. The operative mortality among 147 cases of valvular disease was only 2.1 per cent, and among 103 cases of auricular fibrillation only 3.0 per cent. Of those afflicted with angina pectoris, which usually occurs at middle age or later, the mortality was high, 7.7 per cent, the most frequent cause being postoperative coronary thrombosis. Those who had suffered a previous attack of coronary thrombosis faced still greater risk. Hypertension was infrequently a cause of death, it was found, but the mortality rate among patients with nephritis was three times as high as for those without nephritis. It may be added that from the standpoint of prognosticating the outcome of a major surgical procedure on the patient with chronic nephritis, anemia, failure of concentration of urine above 1.015 and an elevated nonprotein nitrogen content of the blood are of about equal seriousness. The cardiovascular and renal systems are so closely interlinked that in nearly every case in which preoperative evaluation is necessary, the renal as well as the cardiac functions must be carefully measured.

Certain generalizations can be made respecting the risk of operating on patients afflicted with various types of cardiac abnormalities. Compensated heart disease, whether it be rheumatic, arteriosclerotic, or hypertensive, does not greatly increase the risk involved in surgical procedures. If the operation is one that will cause the entry of bacteria into the blood stream, the danger of engrafting infection upon the endocardium previously damaged by rheumatic infection should be prevented by administering a suitable sulfonamide or penicillin. The patient with syphilitic cardiovascular disease, however, is subject to the danger of postoperative accident. The same is true of the patient with severe coronary artery disease, with or without occlusion. A history of angina pectoris is important. Master, Dack, and Jaffe[12] have discussed this particular problem on the basis of 35 known and 13 probable cases of coronary occlusion in Mount Sinai Hospital, New York, between 1931 and 1937. In three-fifths of them pain was absent, probably because of the sedatives and narcotics used postoperatively. Two-thirds of them were 60 years old or older, only 4 under 50, and there were five times as many men as women. All presented evidence of moderate to severe coronary artery disease. Slightly more than half the attacks of postoperative occlusion occurred within three days after the surgical procedures. The type of anesthetic used had no bearing, but the presence of postoperative shock with tachycardia, low blood pressure, and diminished blood volume was significant. Patients who have had previous coronary occlusion need not be poor surgical risks, but the possibility of accident does exist.

The presence or absence of cardiac murmurs and the location of valvular disease are not significant.

Arrhythmias

Cardiac arrhythmias such as extrasystolic arrhythmia, sinus arrhythmia, supraventricular paroxysmal tachycardia, auricular flutter, and auricular fibrillation are not in themselves serious contraindications to surgical procedures. Uncontrolled fibrillation with an apical rate above 90, especially if there is a pulse deficit, calls for digitalization, or in some instances quinidine administration prior to operation, however. Then the hazard is little greater than in an analagous situation without arrhythmia. The arrhythmias that are apt to lead to sudden death are heart block and ventricular tachycardia.

Decompensation and Embolism

The existence of cardiac decompensation is the most serious of problems when operation becomes necessary. The association of gallop rhythm in the decompensated individual or the presence of pulsus alternans adds to the seriousness of the situation. With the ready availability of the isolated digitalis principles, it is possible to digitalize completely in a few hours and thus minimize the risk. Obviously this is not the ideal solution, for a rest of some days is also advisable, but sometimes delay is not permissible.

Cardiac asthma deserves special attention, for its true significance may be overlooked. Attacks of paroxysmal dyspnea, characteristically nocturnal, indicate failure of the left heart and are always of serious import, indicating a life expectancy of less than two years. These patients require preoperative digitalization, and a postoperative attack of dyspnea, if it occurs, should be promptly controlled with the application of a tourniquet to each of four extremities for fifteen to twenty minutes to decrease return of venous blood to the heart. This also serves as a test in differentiating cardiac and bronchial asthma.

The hazard of postoperative pulmonary embolism, a hazard that is significantly greater for the cardiac patient with auricular fibrillation and is especially great if there be decompensation or borderline compensation, can be lessened by digitalization where indicated and by the proper use of the anticoagulants, heparin and dicumarol, and other prophylactic measures. No cardiac state except subacute bacterial endocarditis contraindicates anticoagulant therapy.

Summation

From the experience of others as well as ourselves, then, one might state that when dealing with the cardiac patient about to undergo a major surgical

procedure, one should carefully evaluate his status by taking a detailed history with especial attention to the history of precordial pain, dyspnea, swelling of the ankles, and unexplained fatigue; by making a careful and complete physical examination, and by employing the indicated laboratory procedures. The laboratory procedures most commonly indicated are the urine analysis with especial attention to the specific gravity, presence or absence of albuminuria and the microscopic findings; the blood count to exclude anemia; the nonprotein nitrogen of the blood; the vital capacity, and the electrocardiogram. Of these, the history is of paramount importance, for it is the ability to withstand the stress and strain of daily life, the carrying on of one's occupation, walking and stair-climbing, and other mental and physical activities that are the most helpful evidence of the heart's functional condition. The decompensated patient is the poorest risk, but he can usually be made a satisfactory risk by proper rest, the reduction of salt in the diet, digitalization, and the use of an acidifying salt and diuretics. The choice of surgeon is important, and the choice of anesthetist is more important than the anesthetic. At best the occasional postoperative accident is bound to occur, but the hazard can be diminished by proper preoperative study and care. And, it must not be forgotten that accidents do occur in noncardiac patients too.

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Evaluation and Management of the Cardiac Patient for Anesthesia and Surgery*

By FRANCIS F. ROSENBAUM, M. D.
Milwaukee

F. F. ROSENBAUM

Doctor Rosenbaum, assistant clinical professor of medicine at Marquette University School of Medicine, received his medical degree from the University of Michigan Medical School in 1936. Following a two year residency in medicine at the Peter Bent Brigham Hospital, Boston, he joined the staff of the University of Michigan Medical School. In 1946 he entered the practice of cardiology in Milwaukee.

FOR the most part, patients with heart disease withstand surgical procedures nearly as well as normal individuals. Not only should it be emphasized that there is need for accurate surgical and cardiac diagnosis in these patients, but it must be made certain that the cardiac disorder is not solely responsible for the patient's symptoms and, further, that the heart disease present carries a life expectancy of sufficient duration to warrant the risk of the contemplated surgical procedure.

* Presented in part as the discussion of the paper "Evaluation of the Cardiac Patient for Anesthesia and Surgical Procedures" by Dr. O. O. Meyer at the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

There have been several clinical and experimental observations reported recently which bear importantly upon the greater risk and mortality of surgical treatment in patients with coronary arterial disease. Blumgart[1] has found that shock, no matter how produced, may lead to multiple, as well as single, fresh coronary arterial occlusions in elderly patients with coronary arteriosclerosis. In Masters' cases of postoperative myocardial infarction, the incidence of shock was high.[2] Page[3] has reported that, unlike other vascular areas, the coronary arteries in dogs actually dilate as the arterial pressure falls. Furthermore, the coronary arterial flow in dogs is decreased by 30 to 60 per cent during periods of hypotension due to hemorrhage.[4] Patients who have been operated upon may be unable to distinguish cardiac pain from the various discomforts attendant upon the surgical procedure. Consequently, myocardial infarction occurring during the immediate postoperative period may be overlooked.

The implication of these various observations is clear. In order to reduce the risk of surgical treatment in patients with coronary arterial disease, the following recommendations seem wise: (*a*) The operation should be delayed until the cardiac disorder has become stabilized. It is now recognized that patients whose cardiac pain is changing—that is, becoming more severe, more frequent, or occurring on lesser stress—may be having premonitory manifestations of myocardial infarction[5] or may already actually have had an infarct.[6] Surgical procedures should be postponed until the pain has become stable in its character. Electrocardiographic observations may be especially helpful in patients of this type. If there has been a recent myocardial infarction, the operation must wait until the cardiac lesion heals completely. This usually requires three to four months. Of course, it is true that delay may be impossible in dealing with acute surgical emergencies. (*b*) Shock and especially prolonged hypotension should be avoided. (*c*) If shock or dehydration should occur, the complication must be treated promptly and adequately. Transfusion appears to be the most certain means of preventing cardiac damage in shock.[3] Parenteral fluids and blood must be given cautiously, however, to avoid overloading the circulation by suddenly increasing the total circulating blood volume. The sympathomimetic drugs must be

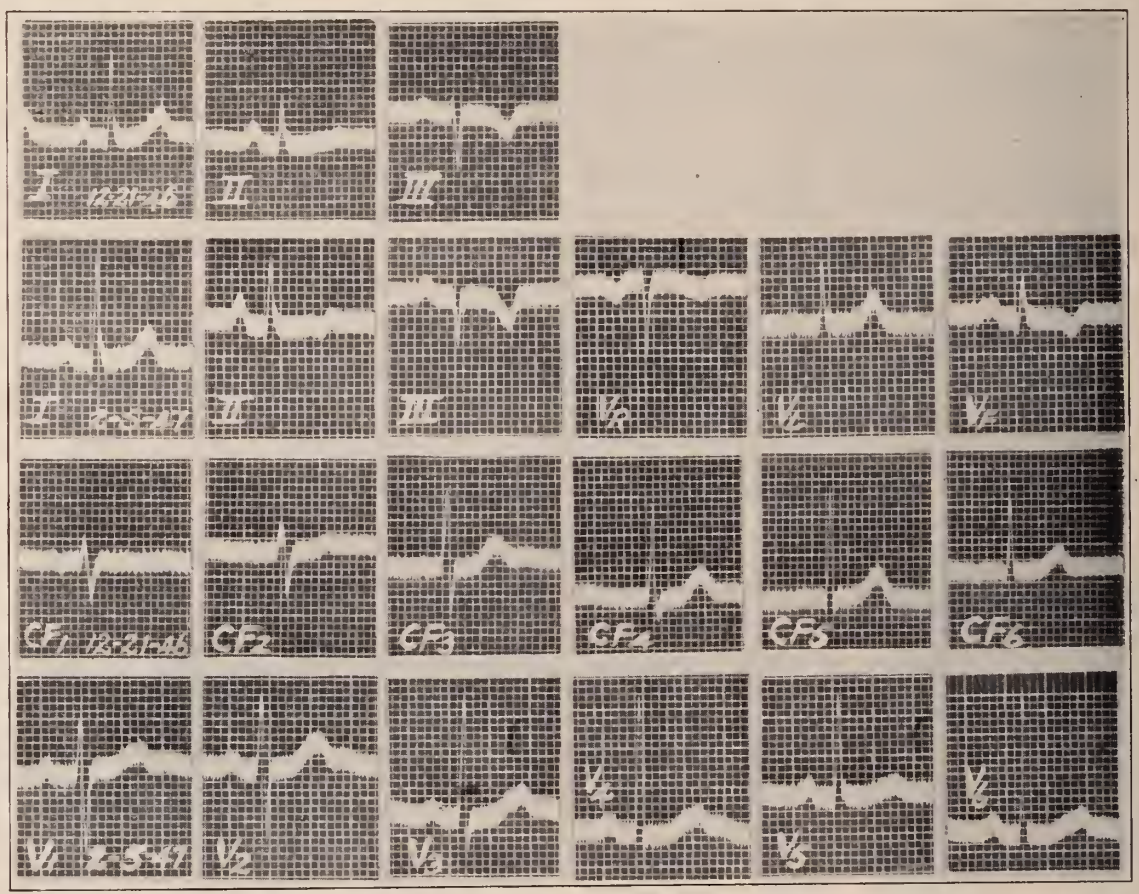

Fig. 1 (case 1).—Electrocardiograms of a 61 year old housewife with angina pectoris. Those taken on Dec. 21, 1946, are normal except for slight left axis deviation. Severe precordial pain occurred on Dec. 31, 1946. The limb leads taken on Feb. 5, 1947, show Q waves and inverted T complexes in leads II, III, and V_6. The R and T waves have become taller in leads V_1 and V_2. The changes suggest a recent posterior myocardial infarction. Cholecystectomy and appendectomy were performed on April 9, 1947.

used carefully, if at all, lest angina pectoris or prolonged coronary arterial spasm be produced. An example of the type of problem which is encountered in patients with coronary artery disease is given in case 1.

CASE 1.—D. T., a 61 year old housewife, was first seen in consultation with Dr. H. W. Pohle on Dec. 26, 1946. She had had angina pectoris for over two years. The distress occurred more commonly after eating. There was a history of epigastric discomfort related to eating and intolerance to fatty foods. Roentgenographic studies in July 1944 and September 1946 disclosed cholelithiasis, some duodenal deformity, and a small hiatus hernia. The blood pressure was 140/72. There was moderate retinal arteriosclerosis. The heart was normal in size, the cardiac sounds were of normal character, and there were no murmurs. The physical examination disclosed no other abnormalities. Cholecystectomy was recommended in the hope that it would benefit the cardiac pain and plans were made for this procedure.

On Dec. 31, 1946, the patient began to have a series of more severe, prolonged attacks of cardiac pain. She was confined to her home for one month. When she was seen on Feb. 6, 1947, there was no significant change from the initial examination. The electrocardiograms on this occasion (fig. 1) showed small Q waves and slight inversion of the T waves in leads II and V_F and distinct Q waves and deep inversion of the T waves in lead III. The T waves were more upright and the R waves more prominent in leads from the right precordium than in corresponding records taken on Dec. 21, 1946. These changes indicated that the patient had had a recent posterior myocardial infarction and the history suggested that this had occurred one month earlier. Cholecystectomy was delayed, therefore, until the zone of infarction healed.

The patient was admitted to Milwaukee Hospital on April 8, 1947. There had been no change in the clinical picture. Cholecystectomy was performed on April 9, 1947, by Dr. C. W. Eberbach. Appendectomy was also done because the appendix was found to lie very high, and it came into view immediately when the incision was made. Ethylene, ether, oxygen, and curare were employed by the anesthetist. The gallbladder showed chronic cholecystitis and cholelithiasis. Only minor changes in the heart rate and blood pressure occurred during the operation. Oxygen was administered for twenty-four hours postoperatively. The convalescence was entirely uneventful. She was out of bed on the sixth day and discharged on the twelfth postoperative day. The operation was followed by striking improvement in the cardiac pain.

Patients who have cardiac disorders associated with congestive heart failure or potential cardiac decompensation present problems of a somewhat different character. The usual program for management of congestive heart failure must be employed to get these patients into the best possible condition prior to operation. Mild ambulation prior to operation is a better preparation for these patients than strict confinement to bed, but too much exertion may cause a recurrence of heart failure. Digitalis should be given preoperatively only if the usual indications of congestive failure or auricular fibrillation exist. It should not be given to "tone up the heart" or merely because heart disease is known to be present.[7] If the need for digitalis arises postoperatively, cardiac glycosides such as digoxin or strophanthin can be given parenterally for rapid effect. The fact that patients with severe cardiac decompensation can tolerate surgical procedures after a period of adequate preparation is demonstrated by case 2.

CASE 2.—E. F., a 68 year old housekeeper, was seen first on Oct. 4, 1946, because of severe dyspnea and ankle edema. There was a typical history of progressive, severe cardiac decompensation for one year. The patient had severe orthopnea, gross cardiac enlargement, murmurs suggesting mitral stenosis and insufficiency, and aortic stenosis, hepatomegaly, and moderate peripheral edema. The blood pressure was 178/90. The congestive heart failure was relieved on a program of digitoxin, ammonium chloride, low-salt diet, and gradual ambulation. Ultimately, she became able to resume nearly all of her household duties except for the more strenuous chores. Compensation has been maintained on this same program. An electrocardiogram on Nov. 12, 1946, disclosed left bundle branch block (fig. 2). Fluoroscopic examination of the heart revealed calcification of the aortic valve. On Dec. 16, 1946, a tumor was discovered in the left breast with associated distortion of the left nipple. She refused operation at this time. Over the succeeding nine months the tumor increased in size, and lymph nodes became palpable in the left axilla. Local excision was advised in order to prevent the possibility of ultimate local breakdown and sloughing. It was felt that her cardiac condition would not permit radical mastectomy.

The patient was admitted to the Milwaukee Hospital on Oct. 7, 1947. Preoperative examinations of the blood, urine, and blood nonprotein nitrogen were negative. On Oct. 8, 1947, a simple mastectomy was performed by Dr. C. S. Rife. The anesthetic was ethylene and oxygen with a closed technic. The pathologic diagnosis was infiltrating adenocarcinoma of the breast, grade II. The postoperative convalescence was entirely uneventful. The patient was out of bed on the first and left the hospital on the tenth postoperative day.

This patient had serious heart disease of rheumatic and arteriosclerotic origin. Congestive heart failure had been so severe at one time that she was given a prognosis of only a few days. Her response to adequate management was gratifying. While still well compensated she tolerated an anesthetic and a moderately severe surgical procedure with even less disturbance than the average normal individual. Continued ambulation and proper treatment of the cardiac decompensation up to the time of operation were undoubtedly important factors in her operative course.

There are a few precautions which seem indicated in the postoperative management of patients with actual or potential cardiac decompensation. If parenteral fluids or blood are given, they must be administered slowly and in cautious amounts to prevent sudden increases in the circulating blood volume and precipitation of acute pulmonary edema which may be fatal. The rate of administration probably should not exceed 300 cc. per hour. Fluids containing sodium must be avoided if the patient has had congestive failure, and they are probably unwise in all cardiac patients in times of stress.[8] Oxygen should be used freely postoperatively if there is any suggestion of circulatory embarrassment, and in some cases it may be beneficial preoperatively. If acute pulmonary edema does develop, in addition to

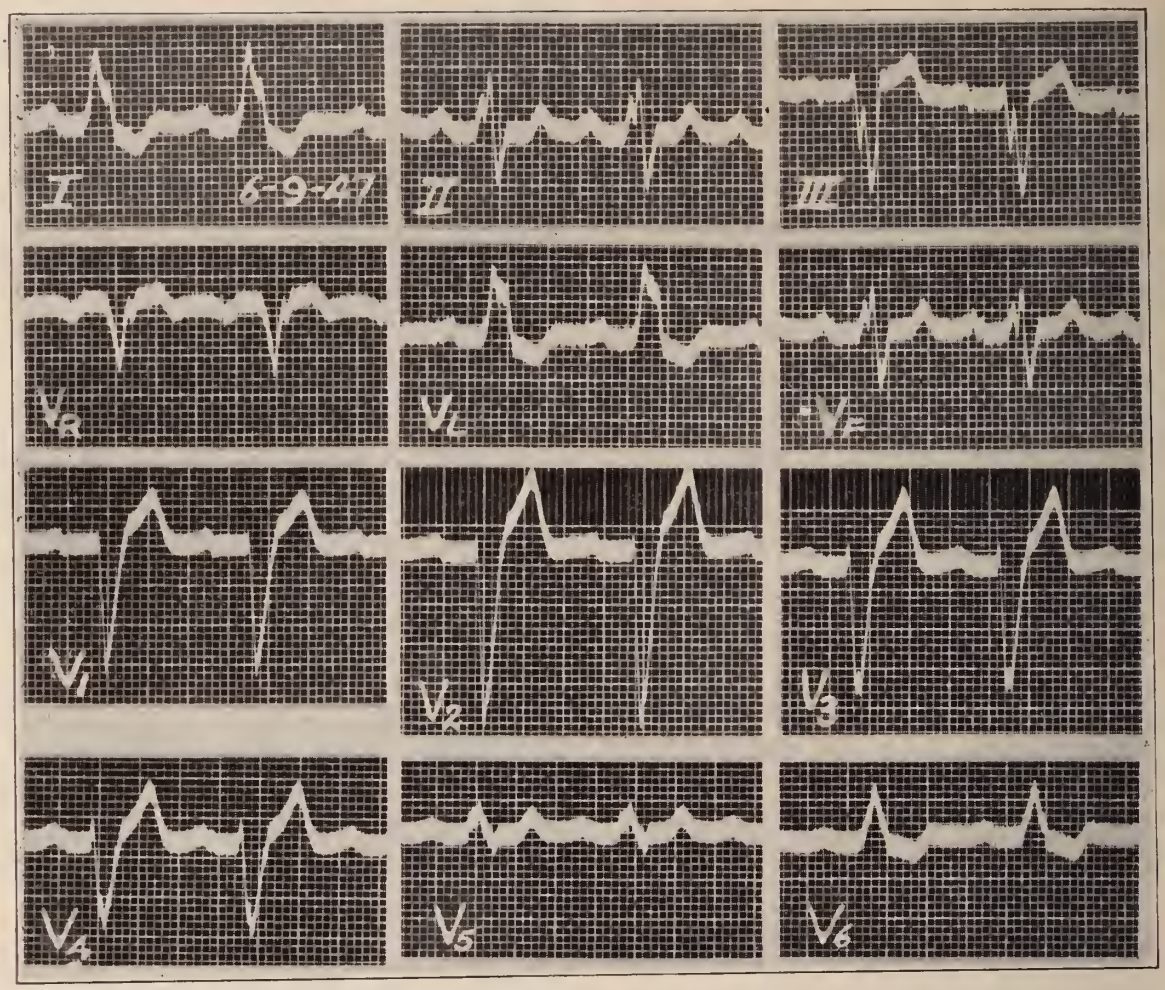

Fig. 2 (case 2).—Electrocardiograms of a 68 year old housekeeper with rheumatic and arteriosclerotic heart disease and severe heart failure. The standard and unipolar limb leads and multiple precordial electrocardiograms on Nov. 12, 1946 (not reproduced) and June 9, 1947, are characteristic of left bundle branch block. Simple mastectomy was performed for carcinoma of the breast on Oct. 8, 1947.

the more usual measures, venous tourniquets on all four extremities may reduce the circulating blood volume by as much as 1 liter.[9] Large, wide blood pressure cuffs maintained at just above the diastolic level are more satisfactory for this purpose than most other tourniquets. Oxygen administered under positive pressure may be helpful in preventing further exudation of fluid into the lungs. If the patient does not improve promptly, one should not hesitate to resort to venesection, with removal of 500 to 1,000 cc. of blood. The greater hazard of pulmonary embolism in patients with heart disease,[10] especially those with increased venous pressure and congestive heart failure, is an added reason for early postoperative ambulation in cases of this type. The value of venesection in cardiac patients in whom acute pulmonary edema develops during anesthesia or surgical procedures is illustrated in case 3.

Case 3.—L. Z., a 34 year old housewife, was first seen on April 25, 1947. She was in the second trimester of her third pregnancy. Rheumatic heart disease had been recognized during her initial pregnancy eight years before. Symptoms of cardiac weakness appeared at seven months during the first pregnancy and at three months during the second pregnancy. The characteristic physical findings of rheumatic heart disease with mitral stenosis were present. There was evidence of low grade congestive heart failure. Fluoroscopic examination disclosed left auricular enlargement, and the cardiac frontal area was increased 66 per cent above the predicted normal (fig. 3). In June she began to have repeated hemoptyses. She was admitted to the Milwaukee Hospital from June 14 to July 3 for management of the cardiac decompensation.

There was some recurrence of heart failure following her discharge, but the patient was ambulatory until readmitted to the Milwaukee Hospital for delivery on August 14 by Dr. F. J. Hofmeister. Labor was induced by rupture of the membranes. Shortly after the membranes were ruptured the patient began to wheeze and complain of dyspnea. Cyanosis, labored respiration, and extensive pulmonary edema followed shortly. The patient's condition worsened so rapidly that it was not possible to use spinal anesthesia as had been planned originally. Anesthesia consisted of scopolamine, Demerol, small amounts of ether and oxygen, and local anesthesia of the outlet. The actual labor was of only one-half hour duration,

Fig. 3 (case 3).—The patient was a 34 year old housewife with rheumatic heart disease and congestive heart failure seen during her third pregnancy. The roentgenogram of the chest and heart on June 24, 1947, shows the characteristic changes of mitral stenosis. Delivery on Aug. 14, 1947, was complicated by severe acute pulmonary edema; relief followed venesection.

but during that period, the patient's condition became critical. The pulmonary edema was not affected appreciably by atropine hypodermically (0.0006 Gm. —1/100 grain), venous tourniquets on all extremities, aminophyllin (0.5 Gm.—7½ grains) in 50 per cent glucose given intravenously, or oxygen administered under slight positive pressure. Venesection with removal of 500 cc. of blood was done. Definite improvement followed within one hour, and nine hours later the lungs were completely clear. The postpartum course was longer than usual but not eventful in other respects.

The various steps taken to combat the acute pulmonary edema in case 3 were probably life-saving. It is difficult to be certain which measure was most important in this case, but it was our impression that the venesection was followed by the most significant response. The hazard of acute left heart failure must be anticipated in following cardiac patients through surgical and obstetric procedures. Preparations must be made to meet such a problem, thereby avoiding any delay, which may be disastrous. If other measures are ineffective, venesection with removal of 500 to 1,000 cc. of blood may save the patient from catastrophe.

Individuals who are subject to paroxysms of significant cardiac arrhythmia may be prepared for operation by prophylactic preoperative medication. Quinidine is usually effective in preventing paroxysmal supraventricular or ventricular tachycardia, as well as paroxysmal auricular fibrillation or flutter. It may be given in doses of 0.2 Gm. (3 grains) for two or three doses at hourly intervals immediately prior to the operation. Digitalis is more effective than quinidine in occasional instances, and in such cases it is usually well to digitalize the patient completely in the usual fashion. It is usually wise to avoid those anesthetic agents such as cyclopropane and chloroform, which tend to produce cardiac irregularities, when dealing with cases of this type.

Conclusion

Surgical procedures in patients with heart disease call for close cooperation of the physician, anesthesiologist, and surgeon, in order that the potential hazards may be evaluated and anticipated. The risk of anesthesia and surgical treatment in patients with heart disease can be reduced by appropriate management to a level only slightly greater than that in patients with normal hearts.

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Duodenal Diverticula*

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Sheboygan

J. W. McROBERTS

Doctor McRoberts received his medical degree from McGill University Faculty of Medicine, Montreal, Canada in 1929. Following graduation, he joined the staff there as instructor in pathology. From 1931–1934 he was a fellow in surgery at Mayo Foundation, Rochester, Minn. Since 1937 he has been in the department of surgery at the Sheboygan Clinic. During 1942–1945 he served with the Forty-Fourth General Hospital as chief of the surgical service. He has been certified by the American Board of Surgeons.

UNTIL the past ten years the subject of duodenal diverticulum was mentioned rather infrequently in the literature, and most writers dismissed the subject with the comment that they were rare and when present caused symptoms very infrequently. Recent literature contains numerous papers concerning this condition, and the attitude of the writers has definitely changed concerning its importance. My interest in this condition has been stimulated since I removed a large duodenal diverticulum a few months ago in a patient, and I wish to present this case in some detail.

Two types of duodenal diverticula are recognized —the primary type, in which there is no obvious cause, and the secondary, which is the result of some local pathologic change in or around the duodenum. The primary type is the most frequent and usually occurs in the second part of the duodenum. It also occurs in the third and fourth parts, but rarely in the first part. In Morton's series of operated cases, 65 per cent occurred in the second part of the duodenum. The primary type arises from the concave pancreatic side of the intestine in close association with the common bile duct, pancreatic duct, or the blood vessels which supply the part. The diverticula are often multiple. They are found most frequently in the midde age group. Apparently, they occur with equal frequency in both sexes. Microscopically, they are found to be made up of the mucous and submucous coats and give the impression that they have herniated through a defect of a muscular coat.

The sac itself may be globular, flask-like, or cylindric. In many of the cases the fundus of the sac is found beneath or in close relationship to the pancreas, but occasionally it may project anteriorly from its origin on the medial side of the bowel. Not infrequently islands of aberrant pancreatic tissue are found in the wall.

There is a wide divergence in the figures given as to the incidence of this condition. According to the reports of roentgenologic studies, the incidence varies from 0.016 per cent (Rankin and Martin) to 5.9 per cent (Cryderman). From autopsy material, Rosenthal gives an occurrence rate of 3 per cent and Schuppel, 5.5 per cent. Ackermann, in 1943, made some precise anatomic studies on this condition by making plaster of paris casts of the duodenum in 50 consecutive bodies. He found a total number of fourteen diverticula in the 50 bodies studied, which is a percentage of 28.

It is practically impossible to make a diagnosis of this condition on the history or physical findings. There is no definite clinical picture which can be described as indicative of the disease. A large number of patients with this anomaly give no symptoms at all. On the other hand, many patients present symptoms simulating gallbladder disease or of the peptic ulcer syndrome. A number also complain of such indefinite symptoms as flatulent dyspepsia or colitis. When complications such as obstruction of the common bile duct, perforation, ulceration, or hemorrhage occur, the clinical picture varies with the complication. It is obvious that not every patient who has a duodenal diverticulum should be operated upon. In the absence of complications these patients can be treated satisfactorily by the use of a bland diet, antispasmodic drugs, and the use of such positions which facilitate drainage of the sac. The presence of definite complications of symptoms related to the diverticulum as outlined below require surgical operation. Morton lists the indications as follows:

A. Mechanical
   1. Symptoms from stasis in the diverticulum.
   2. Symptoms from obstruction of the biliary tract, pancreas, or duodenum.

B. Inflammatory
   1. Primary diverticulitis or perforation.
   2. Secondary inflammation of the biliary tract, pancreas, duodenum, or retroperitoneal tissues.

C. Neoplastic change

The surgeon is confronted with a responsibility when it is determined that a patient with upper abdominal symptoms is found to have a duodenal diverticulum by x-ray examinations. He is then faced with the problem, "What to do about it?"

If the x-ray films show that the barium is trapped in the diverticulum and is retained there after the stomach is completely emptied and if localized pres-

* Presented before the Wisconsin Surgical Society, Milwaukee, February 1948.

sure over it causes pain, one may conclude that in the absence of other pathologic changes in and around the duodenum, the diverticulum is responsible for the symptoms. Therefore, one is justified in urging that the diverticulum should be removed.

In regard to the removal of the diverticulum by operation, there are several points to be borne in mind. In its most frequent situation, arising from the second portion of the duodenum, it is in close association with the common bile duct, the pancreatic duct, and the pancreas itself. When the fundus presents itself anteriorly it is very easy to excise it without danger to the adjacent structures.

However, when the main portion of it is posterior to the pancreas or the duodenum, a precise technic must be used. The posterior peritoneum to the right of the duodenum is incised, and the duodenum can be drawn to the left. The diverticulum can be drawn to the right by the use of dissection and gentle traction. Pearse advises that the sac should be divided down its middle to within ½ inch of the duodenum. It is then possible to look into the duodenum and locate the position of the ampulla of Vater. Probes can be placed in the openings of the common bile duct and the pancreatic ducts for positive identification. The sac should be excised, leaving a margin of about ½ inch to be certain that in the closure and invagination of the sac the common bile duct or pancreatic ducts will not be caught in the sutures.*

At the time of operation the diverticula may be collapsed and very hard to identify. To facilitate their identification and position, Mahorner has suggested the inflation of the duodenum by the means of injected air into it. When the duodenum is ballooned, the diverticula may be easily identified even if they are located in the pancreas or behind the duodenum.

When the diverticulum is buried in the head of the pancreas, and dissection and excision may prove hazardous, Maclean has advocated opening the duodenum and inverting the sac within it.

Diverticula arising from the superior concave border of the third portion of the duodenum are approached through an incision in the superior leaf of the transverse mesocolon. If they originate to the left of the superior mesenteric vessels, a better exposure is obtained by lifting up the mesocolon and incising from below.

Report of a Case

A woman, 59 years of age, entered St. Alphonsus Hospital, Port Washington, in August 1942, because of gastrointestinal symptoms of many years' duration. The examining physicians described her symptoms as like that of chronic gallbladder disease, with gas and belching after eating. The pain itself was in the gallbladder area but did not radiate to the back. Incidentally, the history noted that she also complained of a tightness in her chest and shortness of breath, especially at night.

Physical examination revealed tenderness in the upper right quadrant. No masses were palpable. Examination of the cardiovascular system revealed a systolic murmur over the mitral area. Blood pressure was 160/110. X-ray examinations were made of the gallbladder, colon, and stomach. Examination of the gallbladder with oral dye revealed no concentration of the dye in the gallbladder. No opaque shadows were seen. A barium enema revealed several diverticula in the distal sigmoid. Examination of the stomach was negative, but there was, however, a large diverticulum which apparently had its stoma at the proximal portion of the descending ramus of the duodenum. A film taken one hour following a barium meal revealed normal emptying of the stomach, but the diverticulum of the duodenum contained more barium and measured about 4 by 5 by 3 cm.

The patient was treated conservatively and placed on a medical regimen, but her complaints persisted. She was readmitted to St. Alphonsus Hospital in June 1947. At this time, she complained of gas in her stomach, especially after eating, and intolerance to fatty foods and uncooked fruits and vegetables. She also complained of a rapid and irregular heart action, and stated that she had a constant fear of impending death. On physical examination on this admission, the physician stated that the abdomen was soft and gaseous. The gallbladder area was filled with gas. On palpation gas could be freed from the region of the gallbladder, but immediately refilled without sensation to the patient. On this examination the blood pressure was determined at 180/90. The heart rate was rapid, but no irregularities were found. X-ray examination of the colon by barium enema revealed many diverticula in the sigmoid, similar to those seen at the examination in 1942. X-rays of the stomach and duodenum showed the presence of a large radiolucent shadow containing air in the region of the gallbladder. Barium could not be forced into it. It was surmised that there might be a fistula between the intestinal tract and the gallbladder. Electrocardiographic examinations were done on two occasions during this admission to the hospital. The report was as follows: left axis deviation, myocardial changes of the coronary type, coronary insufficiency.

An exploratory laparotomy was performed on July 17, 1947, through an upper right rectus muscle-splitting incision. The gallbladder appeared to be normal. Further exploration revealed the presence of a large well formed diverticulum of the descending portion of the duodenum. It was covered with peritoneum and appeared to arise from the anteromedial aspects of the duodenum. It measured about 1½ inches at the base and was approximately 3 inches long. After the posterior layer of peritoneum had been opened, the diverticulum was excised at its base. The opening in the bowel was closed with one layer of continuous chromic catgut and another layer of continuous overlapping Lembert sutures, and strengthened with interrupted sutures of silk. The postoperative condition of the patient was very good. The patient seemed well on the road to recovery until the morning of the fifth day, when she suddenly became cyanotic and the pulse became imperceptible. She died in a few hours.

A postmortem examination was done by Dr. L. J. Van Hecke. The significant findings were as follows:

* Erwin Schmidt points out that owing to the anatomic variations in the components of the ampulla of Vater it is often very difficult to identify the termination of the common duct, even when the duodenum is opened. He suggests that it is better to open the common duct and to pass a probe through it into the duodenum.

The gallbladder was markedly distended and tense. When opened it contained a large amount of dark green bile. The wall of the gallbladder was thin. The common duct, when followed down to the duodenum, seemed to enter an inflammatory area, apparently a result of a recent excision of a diverticulum. There was some partial obstruction of it, but a probe could be passed through it into the duodenum. The operative wound of the duodenum was healing well without any evidence of leakage. The large bowel showed segmental distention and a number of diverticula in its wall. The pathologist's anatomic diagnosis was as follows: (1) coronary occlusion with myocardial infarction, recent and old; (2) fibrinous endocarditis; (3) generalized arteriosclerosis; (4) status four days following diverticulectomy of the duodenum; (5) marked pulmonary edema and hydrothorax; and, (6) hypernephroma of the left kidney.

Cause of death was given as coronary occlusion with myocardial infarction.

Pathologic examination of the diverticulum was as follows: This specimen is a diverticulum which has a rather broad base. It is 5½ cm. in length at its base and 3.5 cm. in width. When it is opened it is seen to have the typical folds of mucous membrane of the bowel. The point of clamping when stretched out occupies a rather broad base. There is no gross evidence of inflammatory reaction.

Microscopic Findings.—Microsection was examined which showed abundant folds of small bowel mucosa not unlike that seen within a Meckel's diverticulum. The mucous membrane was evidently hypersecretive. There were only small elements of muscle.

The pathologic diagnosis was duodenal diverticulum.

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The State Bureau of Alcohol Studies requests the cooperation of all Wisconsin physicians in supplying certain information concerning the treatment of alcohol addiction. Please answer the following questions and mail the form to the Bureau of Alcohol Studies, State Department of Public Welfare, Capitol Building, Madison, Wisconsin.

1. Approximately what percentage of your practice consists of the treatment of:
   (a) alcohol addiction (drinking habit), per cent or number of patients
   (b) acute alcoholic intoxication, per cent or number of patients
2. What institutional facilities, if any, do you use for the treatment of:
   (a) alcohol addiction
   (b) acute alcoholic intoxication or psychosis
3. Check the types of treatment you use in cases of alcohol addiction:
   Psychotherapy
   Individual
   Group
   Psychoanalysis
   Hypnosis
   Shock Therapy
   Conditioned Reflex
   Specific Drugs or Medication
   Nutritional Therapy
   Other Therapies (list)
4. Do you utilize auxiliary help, such as:
   Alcoholics Anonymous _____
   Religious Advisers _____
   Others (list) _____
5. If you do not treat alcoholic patients, to whom do you refer them?
   Hospitals_____ Physicians_____ Alcoholics Anonymous_____
6. What, in your judgment, is the best way to deal with this problem insofar as it concerns the management of:
   (a) acute intoxication _____
   _____
   (b) chronic addiction _____
   _____
7. Would you be willing to have this matter discussed with you at greater length by our representative?_____ If so, give your name and address _____

Antibiotics in Ear, Nose, and Throat*

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SAMUEL SALINGER

Doctor Salinger, a graduate of Loyola University School of Medicine, Chicago, is now professor and head of the department of otolaryngology at that institution. In addition to his teaching duties, he is also senior attending otolaryngologist at Michael Reese Hospital and attending otolaryngologist at the Illinois Charitable Eye and Ear Infirmary.

THE widespread use of antibiotics in recent times has brought about a marked change in the therapy of many diseases of the ear, nose, and throat. Following the initial enthusiasm which always accompanies the introduction of a new remedy comes a period in which we take stock of and attempt to evaluate the effectiveness of the drugs. From the mass of literature which has been piling up and from our own individual experience we should have sufficient data to clarify our views and possibly set forth certain rules of procedure which will insure the maximal beneficial results with the minimal risks.

Certain phases of the subject are clear and can be universally endorsed. Others are obscure and require further study and investigation.

Proved Facts

We can all agree that antibiotics have reduced the incidence of otitic complications to such a degree as to establish the indisputable value of the therapy. The marked decrease in the number of mastoid operations tells the story in unmistakable terms.

The same applies to acute infections of the nose and throat, where the duration of the infection and the percentage of complications has been materially reduced.

In the presence of serious complications such as osteomyelitis and intracranial involvement, antibiotics have served to isolate and control the infection to the point where surgical treatment, when necessary, can be safely employed.

In the presence of trauma, both surgical and accidental, antibiotics have proved most effective in preventing infection and promoting healing.

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

Complicating Factors

These are all well documented facts which are generally accepted and admit of no controversy. However, there are certain factors relating to antibiotic therapy which give us pause for reflection and which require further study and consideration. These are (1) toxic reactions, local and constitutional; (2) bacterial resistance after previous administration of the drug; and (3) alteration of the clinical picture.

These factors must be carefully analyzed, since the answers may hold the key to many of our difficulties. How are we to overcome the nausea and vomiting frequently observed with sulfonamides, the hematuria and anuria of sulfadiazine, the eruptions and anaphylactic reactions accompanying penicillin and the other drugs, and the vestibular and cochlear disturbances which have been noted with streptomycin?

As for item 2, what should be our policy in cases in which the bacteria have become penicillin fast? Since the incidence of this phenomenon can never be foretold, shall it act as a deterrent to the use of the drug or do we have the right to ignore this possibility?

Concerning the change in the clinical picture frequently observed in the otitic cases, how shall we be guided? When the temperature is down, the leukocyte count depressed, and the x-ray picture obscure, how shall we determine whether the mastoid needs to be opened?

In addition to the items just mentioned, we have to consider the question of antibiotics in chronic infections. Have these drugs proved of sufficient value to justify their use routinely?

With your indulgence, I should like to set forth my own conclusions on these points as a basis for discussion.

Conservative Attitude

In the first place, I am inclined to be conservative insofar as the routine use of these drugs is concerned. I do not believe it is necessary or advisable to give a sulfonamide drug or penicillin in the average case of acute sinusitis or sore throat, since most of the patients recover spontaneously under conservative palliative measures. Why expose the patient to the possible reactions ensuing from the use of the drugs or the danger of rendering his flora resistant? My only exceptions to this rule are cases accompanied by more than average rise of temperature or when there is a possibility of impending complications.

Local Use

As for the local use of antibiotics, I have not found much advantage in the use of powders, sprays, or inhalations in the average acute nose and throat infection. Besides, it is inconceivable that the brief contact of the drug with the surface can accomplish any more than the neutralization of the surface bacteria. Experiments have shown that bacteria residing in the deeper recesses can be reached only through the circulation.

Acute Otitis Media

As for acute otitis media, it is difficult to withhold penicillin, particularly in children, because of the attitude of the parents as well as the pediatrician. The publicity which this drug has received seems to have convinced the public of its infallibility, and it is almost foolhardy for the otologist to resist. Nevertheless, I am convinced of the value of the drug provided it is intelligently administered and controlled. What I object to is the total reliance on the drug to the exclusion of other factors. We are too often lulled into a false sense of security by the fall in temperature and absence of pain, and fail to perform a needed paracentesis. We frequently disregard recurrence of pain and temperature when the drug is withdrawn, and we pay too little attention to persistent deafness, failure of the drum membrane to clear, and such other significant symptoms as loss of appetite, sleeplessness, pallor, and apathy, all of which may indicate disease within the mastoid or possible intracranial involvement. We must never lose sight of the fact that fundamental surgical principles still hold good. Pus must be evacuated and necrotic tissues removed.

Chronic Otitis and Sinusitis

Finally, I can see no advantage in the use of antibiotics in chronic sinusitis or chronic otitis media, despite the fact that temporary improvement is nearly always observed. The bacterial factor is only one of several factors responsible for the chronicity, and unless all of them are appropriately treated the antibiotic alone will fail.

Conclusions

My feeling with regard to this whole subject may be summed up in this way: Antibiotics are extremely valuable ammunition which, when properly employed, can overcome hitherto resistant and often fatal infections. They should be employed only when strictly indicated and in sufficient amounts according to the severity of the infection and the bacteria involved. They should not be used routinely in minor self-limited infections or in chronic infections to the exclusion of other well founded therapeutic principles.

JACKSON CLINIC AND MARQUETTE UNIVERSITY SCHOOL OF MEDICINE TO HOLD POSTGRADUATE CLINIC

The annual postgraduate clinic presented by members of the faculty of the Marquette University School of Medicine and the staff of the Jackson Clinic will be held November 13, the day of the Wisconsin–Marquette football game.

There will be a medical program in the morning from 9:30 to 12 o'clock given by several leading Milwaukee and clinic physicians, followed by a luncheon at the Loraine Hotel for the doctors and their wives.

Any physician who desires to attend the meeting and luncheon and who does not receive a reservation card may request one by writing Dr. George P. Schwei, chairman. Tickets for the football game may be ordered from the Athletic Ticket Office of the University of Wisconsin.

PROGRAM

9:30: "The Prevention and Treatment of Decubitus Ulcer"—*Dr. Elwyn S. Shonyo*
9:50: "Cancer and the Thyroid Gland"—*Dr. Arnold S. Jackson*
Discussion by _____*Dr. William L. Waskow*
"Symposium on Venous Thrombosis and Pulmonary Embolism"
10:30: "Applied Physiology"—*Dr. Armand Quick*, Milwaukee
10:50: "Clinical Aspects"—*Dean John S. Hirschboeck*, Milwaukee
11:10 "Surgical Treatment"—*Dr. Joseph J. Gramling, Jr.*, Milwaukee
11:30 Discussion of all papers
12:00 Luncheon at the Loraine Hotel for doctors and their wives
2:00 Marquette–Wisconsin football game

A Symposium on Prolonged Labor*

By JAMES H. BLOOMFIELD, M. D.
Chicago

J. H. BLOOMFIELD

Doctor Bloomfield, a native of Michigan, graduated from the University of Illinois College of Medicine in 1913. He served as an intern and resident at the Chicago Lying-In Hospital, where for many years he was associated with the late Dr. J. B. DeLee. Since 1931 he has been in the obstetric department of Passavant Memorial Hospital. At present he is assistant professor of obstetrics at Northwestern University Medical School.

PROLONGED labor dates from antiquity. The progress of the human race in all phases has been rapid. The diminishing time for labor has been slow by comparison. In fact, statistics will show, where no uterine stimulants have been used, that the number of prolonged labor cases has increased. This is brought about in many instances by an easier mode of living.

The advances of surgery, to alleviate either true pelvic pathology or imaginery neurosis, have not lessened the time of labor. Let a woman be told that she has a womb that is tipped or out of normal position, and she at once becomes a subject for much useless surgical treatment, especially if it is associated with any degree of backache.

All pelvic operations should be done with future thoughts of obstetric complications in mind unless sterilization is performed at the time. It is true that in a small number of cases surgical treatment for uterine displacement is beneficial from a sterility standpoint. All operations on the cervix, especially amputations and repeated cauterizations, often lead to a slow dilatation during labor or, less often, to severe tears and accompanying profuse hemorrhages. Displacement operations, by shortening the round and sacrouterine ligaments and advancing the bladder on the anterior wall of the uterus, may cause torsion of the uterus and an unequal hypertrophy of the uterine wall during pregnancy. These all lead to a dysfunction during labor.

The early recognition of other pathologic complications, such as early constriction ring dystocia, so recently and ably described by Rudolph, would shorten labor if appropriate treatment was instituted early. Unfortunately, an early diagnosis is not easily made.

The wise obstetrician is the one who guards his statements regarding the length of time to be consumed in any labor. Labors that extend over an abnormally long time are seen with sufficient frequency that they form one of the major problems of any obstetrician. Not only are they time consuming and lead to exhaustion of both the patient and the attendant, but often they exact demands of the immediate family and relatives. Many lead the younger obstetrician in the pitfalls of a too early intervention, with the too often high mortality and morbidity for both the mother and the child. I am sorry to say that exhaustion on the part of the attendant instead of the patient is little excuse for such intervention. It is true that we should always remember the old axiom, "Never see how much a woman in labor can stand, but note carefully what progress is being made."

Chief among the etiologic factors are (1) lack of expulsion forces in an otherwise normal pelvis; (2) disproportion; (3) abnormal positions of the fetus, including occipitoposteriors; (4) pelvic deformities; (5) rigidity of the cervix; and (6) constriction rings, now believed to occur in various degrees of early labor and recognized more often than formerly. These are not to be confused with the ring of Bandl that usually occurs late in labor.

What should be termed as prolonged labor? At the present time, no uniform length of time is in use. Each large obstetric clinic in this country uses its own length of time as a base for computing prolonged labor. There is also no uniform rule as to when labor starts, although most obstetric teachers will agree that there must be an unfolding of the cervix or effacement, and at least a beginning dilatation of the cervix.

It is not uncommon in multiparous women to find a cervix 2 to 4 cm. dilated in the latter weeks of pregnancy. This condition is often accompanied by Braxton Hicks contractions and leads to false conclusions as to the actual time of the onset of labor. It is true that some of these patients will continue into true labor, and again false conclusions as to the actual number of hours of true labor are falsely made.

Several years ago, a study was undertaken at the Cook County Hospital to find out, if possible, how the fetal mortality could be reduced in these cases. It is unfair to judge private patients and their treatment in modern hospitals with those found in large charity institutions, where many neglected cases are sent from various dispensaries and home delivery services, which, if seen early, would have had appropriate treatment instituted.

Each attending obstetrician was given a six month relay to study and endeavor to find the shortest and

* Presented before the One Hundred Sixth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1947.

safest method for delivery. Rules regarding time of labor and proper care were formulated. True, a great deal of the actual work was done by the resident physicians, and a careful report and suggestions on each case were made by the attendant in charge. Some mistakes were made by residents, who, of course, were not sufficiently trained to recognize certain pathologic labors. The shortest length of labor in 59 reported cases was thirty-five hours and the longest, one hundred and fifteen hours. The fetal mortality was 16 per cent. There was no maternal mortality.

After a careful analysis the following instructions may be helpful:

I. Time in labor
   A. Primipara after true labor pains of twenty-four hours' duration, and multipara after true labor pains of eighteen hours should be considered as prolonged labor.

II. Fluids
   A. 500 cc. per mouth every four hours if tolerated and no vomiting. This to include fruit juices and other fluids.
   B. 10 per cent glucose intravenously up to 3,000 cc. for each twenty-four hours if the following symptoms are present:
      1. Vomiting
      2. Pulse above 100 per minute
      3. Temperature above 99.4 F.
      4. Acetone present in urine
      5. Symptoms of dehydration
   C. Urine
      1. Examined every six hours for acetone and diacetic acid, and output measured.
   D. Blood pressure to be recorded every six hours unless hypertension is present, then as often as indicated.

III. Sedations
   A. If signs of exhaustion or lack of rest are present. Periods of rest are provided after every eight hours of uterine contractions.
   B. Morphine and Demerol with scopolamine and Nembutal may be used. Judgment, of course, rules the frequency of sedation.

IV. As few rectal or vaginal examinations as possible are to be made, minimizing the danger of infections

V. Fetal heart tones are recorded at least every one-half hour

VI. Penicillin is to be administered for prophylactic reasons

VII. Blood typing to be made and donors to be cross matched on account of anticipated postpartum hemorrhages in many of these cases

VIII. No operative procedures to be undertaken unless very definite indications should arise

Other treatment, such as stimulation of uterine contractions by the use of Pituitrin, quinine, or calcium, is placed entirely in the attendant's own judgment. The use of vaginal antiseptics is of doubtful use in preventing infection. Each case must be studied individually during labor to give the best end results.

The proper time for intervention must be carefully studied and carried out on the basis of etiologic causes. Where a disproportion is present but has not previously been diagnosed either by pelvic measurement or by roentgenology—and who of us has not missed diagnosing this type of case?—then the most careful obstetric judgment must be exercised. If the disproportion is absolute and the fetal heart tones are good, abdominal delivery is, of course, indicated.

By what method or type of operation depends entirely on the skill of the operator. The operation of choice if abdominal delivery is necessary is the extraperitoneal type, so fully described by Waters. It is more easily done than the Latzko; either is preferable to the intraperitoneal type. The operation is safe and gives excellent results providing the peritoneal cavity is not entered. This often happens when the operator is not skilled in this type of operation. I have also seen the bladder opened and the ureter cut by fairly well trained operators.

In frankly infected cases in which abdominal delivery must be done only in the interest of the baby and in which rupture or necrosis is imminent, I believe a Porro cesarean section is the operation of choice. Threatened rupture may also be an indication in cases of infection.

Many cases are found with complete effacement present but no dilatation. Under careful asepsis, a finger may be introduced into the cervical opening, the membranes carefully stripped upward, and the cervical ring dilated. Two fingers can then be introduced and more dilatation performed. The overcoming or rupture of this abnormal resistant muscle ring is often followed by a rapid dilatation and normal delivery. Again one often finds a cervix that dilates to 7 or 8 cm. and stops. Careful study should tell whether this condition is due to uterine atony or some dysfunction of the uterus. If due to atony, sedation with a few hours' rest will usually suffice. Labor pains usually resume, and labor terminates normally. If due to a dysfunction and the head is well engaged, Dührssen incisions and forceps delivery may be performed. In a large private practice I have found it necessary to perform Dührssen's procedure only twice in the past ten years. Version and extraction following Dührssen's procedure is not to be advocated. Many of these cases are due to malpositions of the head such as deflections and occipitoposteriors. The membranes are not to be ruptured as there is less danger to the baby when left intact.

Previous amputations of the cervix, in my experience, have not encouraged me to attempt deliveries by the vaginal route. One patient seen in consultation immediately postdelivery had an extensive tear extending into the broad ligament, and she was fortunate indeed not to have died of hemorrhage.

The use of Pituitrin to stimulate contractions and hasten delivery is still looked upon with fear, and it should never be used unless the head is deeply engaged and the cervix completely dilated. Then never over 1 or 2 minims are to be used. Even then, someone to give an anesthetic should be readily available.

Edematous anterior lips of the cervix are more often found in multiparas than primiparas and delay

labor. They may be associated with malpositions of the head. Often all that is necessary is to push the cervix gently up over the head during a uterine contraction. A light anesthetic is only occasionally necessary.

Constriction ring dystocia is now more commonly being recognized as one of the major causes of prolonged labor. Previously it was often confused with the ring of Bandl. The failure of early recognition of this pathologic condition may lead the attendant into many serious complications through no fault of his own. This abnormal circular constriction of muscular fibers occurs at various levels of the pregnant uterus, and may form during either the first or the second stage of labor. Ruptured membranes, malpositions, drugs, or manipulations are not a cause in its formation. In other words, at the present time its exact cause is not known. It divides the uterus into two distinct parts. Any part of the fetus may be incorporated by the ring, or the fetus may be found entirely above the constriction.

During a uterine contraction the upper portion is found very tonic and the lower portion remains very flaccid. Descent of the presenting part remains stationary and often is found to ascend. When statistics show that with less than 10 per cent of these cases the ring can be palpated externally, we can easily understand why an early diagnosis is not made. A careful internal uterine examination will reveal the ring palpable in about 90 per cent of such cases. A deeply engaged presenting part may offer some difficulty to palpation of the ring, and it may become necessary to displace upward in order to do so. Extreme care should be exercised to prevent a prolapse of the cord, and, regardless of caution, this will occasionally add to the complications. The cervix will always hang down in a flaccid condition, or what has often been described as a dilatable cervix. The constriction ring is found immediately above. If no internal examination is made to confirm the correct diagnosis, then it becomes only highly speculative, but very suggestive. We must not be deceived by the flaccidity as to the immediate operative delivery.

Two types of constrictions are found, namely, temporary and permanent. The temporary will relax under anesthesia, sedation, and Adrenalin. Regarding the treatment of constriction ring dystocia, it resolves itself into two extremes, radical and ultraconservative. If the diagnosis is made early and no contrary indications are present, abdominal delivery offers the most conservative method of delivery, with greater assurance for both mother and baby. If diagnosed late, the ultraconservative is best to be considered as laid down for the treatment in all prolonged labor cases.

The use of spinal anesthesia has been reported but not in a sufficient number of cases to draw any definite conclusions. Curare has been thought of, but to my knowledge not tried. The high fetal mortality (32 per cent reported by Rudolph) can be most easily explained by too early operative intervention. Time does not permit for details of this intervention. All conditions must be evaluated in the treatment of this condition and extreme obstetric judgment exercised both as to time and as to type of delivery if we hope to reduce the terrifically high maternal and fetal morbidity and mortality rate.

The management of prolonged labor requires both patience and judgment. Intervention before the cervix is completely dilated or the presenting part deeply engaged may require serious operative procedure. In the presence of fever, nonintervention by operative methods or the minimum of intervention will give better results for both mother and child.

Conclusions

1. Too early and vigorous forceps are to be condemned.
2. A prolonged labor, as such, is not cause for operative intervention unless fetal or maternal distress develops.
3. Progress of labor must be carefully observed.
4. The patient must be watched for signs of exhaustion.
5. Proper supportive treatment with food and fluids plus sedation should be given.
6. A dead fetus automatically releases the attendant from consideration for the baby and allows for any dismembering operation which would be of aid to the mother.

MEDICAL SCHOOL ANNOUNCES COURSE IN DERMATOLOGY

As one of the series of brief practical courses which are offered to physicians by the University of Wisconsin Medical School, an intensive course will be offered in dermatology from November 8 through November 12.

Basic information concerning the anatomy and physiology of the skin, and its significance and importance in the diagnosis of disturbances of the integument will be presented. Tissue examinations, diagnosis of precancerous and cancerous lesions, the pyogenic dermatoses, papulosquamous diseases, dematitis venenata, atrophic and hypertrophic skin conditions, and luetic manifestations will be among the subjects included in this offering.

The course will be under the direction of Dr. Sture A. M. Johnson, professor of dermatology and syphilology, in association with Dr. R. L. McIntosh, and Dr. G. A. Cooper of the department of dermatology at the University of Wisconsin Medical School. The charge will be $25 for the five days' instruction. Application should be made to Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, University of Wisconsin Medical School, 418 North Randall Avenue, Madison 6, Wisconsin.

Comments on Treatment

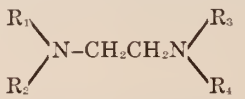
Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

The "Antihistaminic" Drugs

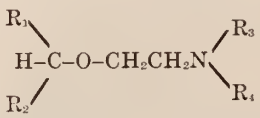
The first members of the antihistaminic family of drugs became generally available to the American medical profession in 1946. The world conflict, with restricted transportation and delayed exchange of information and materials, retarded in this country by several years the knowledge and use of certain of these compounds following their clinical introduction in European countries in 1943 and 1944. American research and the promotional activities of our pharmaceutical concerns have more than compensated for this delay. In the past three years *twenty* different drugs of antihistaminic action have been introduced for clinical use. Definite evidence that further improvement is possible in synthesis of the antihistaminic drugs is the fact that two or three pharmaceutical houses have introduced a second member of this series.

An almost alarming factor is the flood of accompanying literature which is being sent to the members of the medical profession with claims for superiority for each of these twenty compounds. In several instances it seems there merely has been a change in the name of the drug at the head of the table which shows its effectiveness for hay fever, allergic rhinitis, bronchial asthma, urticaria, dermatitis, eczema, drug reactions, etc. Such claims in general probably will require definite revision when adequate clinical data are available for many of the chemicals.

There are two basic chemical structures from which all the antihistaminic compounds have been derived. The first is the ethylenediamine group,



The second is the ether type of drug,



A quite basic similarity can be noted even in these two different types of compounds. In most of the drugs found to be low enough in toxicity but of sufficient therapeutic effectiveness to justify clinical trial, the R_1 and R_2 groups are of a cyclic nature. In a few of the compounds only one of these R groups is a ring structure, and the other is a single methyl, ethyl, or propyl radical. In practically all of the compounds, R_3 and R_4 are simple aliphatic radicals. The latest chemicals proposed in this series have had sulfur substituted in the compounds.

The possibility of substituting anything from simple methyl groups to rather complicated ring structures in four different positions obviously allows the chemist to produce almost a limitless number of compounds. Each one is likely to have slightly different properties from others of a series. On this basis the physician should use two or three different antihistaminic drugs in his practice. A change to a different member often will remove annoying side effects for certain patients. This is true particularly for drowsiness, which probably is the most dangerous of these effects. Fundamentally, however, the pharmacologic effects would be anticipated to be quite similar. Without significant structural changes, no radically greater therapeutic value would be anticipated for one compound in comparison with another. In the final evaluation of a drug many patients must be treated, and adequate time permitted, to learn unfavorable as well as favorable effects. One year, or a season, of trial is not adequate to confirm the advantage in the field of allergic reactions. The same situation prevailed while the barbiturate and sulfonamide family of drugs were becoming established in the medical armamentarium. Gradually from the literally hundreds of compounds tested in each family, a few survived and gained wide clinical acceptance.

A very succinct and extremely comprehensive article by Waldbott, in the *Journal of the American Medical Association* (135: 207–209 [Sept. 27] 1947), presents the basic clinical information necessary for an understanding of this family of compounds. It is especially important to note that the antihistaminic drugs are in no way curative for a condition, and thus do not relieve the physician of the responsibility of establishing the underlying etiology for which treatment is being offered. In many instances today the patient almost stampedes the doctor into prescribing one of these highly publicized antihistaminic drugs and does not wish to spend either the time or money for studies of the real cause of his condition. Such a situation is a hazardous expedient to tolerate in therapy; it may lead to dangerous oversights in diagnosis.

There is also the fact that reports are beginning to appear in the literature of actual sensitization to some of the drugs of antihistaminic nature. Their failure as perfect therapeutic agents plus a real liability in indiscriminate use by the layman is thus made even more apparent and should demand real justification before they are prescribed.—O. S. ORTH, M. D.

for YOUR FILES

ROY T. RAGATZ
Assistant Secretary

C. H. CROWNHART
Secretary

STATE MEDICAL SOCIETY OF WISCONSIN

917 Tenney Building
MADISON 3, WISCONSIN

Dear Doctor:

This communication is addressed to every member of the State Medical Society of Wisconsin who is in any way concerned with the care of students covered by the benefit program of the Wisconsin Interscholastic Athletic Association (WIAA). The successful operation of this program necessitates the best possible medical care given students injured in school activities, at the same time giving the physician attending such injuries a reasonable return for the services rendered.

For more than a decade the WIAA has maintained a benefit program designed to share in part the cost of medical and hospital expenses incurred in connection with injuries sustained in school athletic activities and, more recently, to provide benefits for a wide variety of injuries received on school grounds by children not engaged in formal athletic competition.

Continuous medical direction of the WIAA program has been lacking since its inception, although consultation has been secured from the State Medical Society and one or two Marinette physicians who have given generously of their time. As the program has expanded to cover the majority of high school youngsters in the state, many problems of medical care have arisen and complaints filed with the office of the State Medical Society.

As a means of correcting practices which neglected to take into consideration the services of physicians, the Council on Medical Service and Public Relations appointed a subcommittee to consult with officials of the WIAA program and give the plan the medical direction it obviously needed.

During the past year several meetings of the committee with officials of the WIAA have resulted in a better understanding of the medical problems involved and numerous changes were made which will produce a more satisfactory program. It is gratifying to note that in every instance the suggestions of the committee were not only well received but usually adopted. The magnitude of this program and the obvious need for medical guidance are such that the Council of the State Medical Society has approved its continuance for another year.

In order to avoid further misunderstanding about the program the committee requests all members of the State Medical Society to bear in mind the facts that are presented on the following pages.

J. S. SUPERNAW, Chairman, Sub-Committee on
Wisconsin Interscholastic Athletic Association.

Things You Should Know About the WIAA Program

The Program is Not Full Coverage

Many parents are under the impression that participation in the WIAA program guarantees full coverage for the participant. *This is not true!* At the committee's request, the WIAA is making this point clear to all parents, so there will be no resentment if there is additional billing beyond the maximum allowed on the schedule. However, the total charge for service should not exceed the customary charge for the same service rendered independently of the benefit program. The same principle governs this program as that of the care of veterans: *if the usual charge in the community is below the scheduled benefit, the amount claimed is the lower fee.*

Payments Will Be Made Direct to the Physician

Heretofore the lump sum allowed for the injury has been sent to the school principal and he has distributed the money to the hospital and attending physician. The net result has been a frequent reduction in the amount paid to the physician, with resulting hard feelings toward the entire WIAA program. Beginning with the 1948–49 school year the payments will be made direct to physicians and hospitals.

Follow the Fee Schedule in Your Billing

Much of the confusion of the WIAA in the past has resulted from the rendering of bills without consultation of the schedule. The maximum benefit allowed is the amount given on the schedule, and if your charge is to exceed this amount additional billing to the parent is permitted. *Consult the schedule in your billing!*

Schedule a Favorable One

The schedule of benefits is closely correlated with the schedule of the Veterans Medical Service Agency, which is accepted as a full-payment schedule. It is anticipated that in most instances the maximum allowed under the WIAA program will meet the full fee charged, but in instances where the injury requires an unusual amount of work and the parent is financially able to share the costs with the WIAA program, the patient may be billed an additional sum to provide a total payment somewhat related to the customary charge for the special services rendered. The schedule far exceeds the amounts paid under similar programs in neighboring states.

Not All Injuries Covered

The WIAA program is not all-inclusive coverage. Study carefully the conditions under which the WIAA will not extend protection to students. The injury must be reported to the WIAA within 12 days following injury; officials for athletic contests must be registered and accredited by WIAA; the student must have complied with medical regulations as to remaining out of competition after an injury; and children are not covered for injuries suffered off the school grounds unless they are participating in authorized school activities. It is essential to secure authorization for treatment by reporting the injury to the WIAA on the proper form *immediately after the case has been accepted.*

Simplified Reporting

After consultation with the medical committee the WIAA has revised the forms used for reporting injuries under the program. Now only one form with a minimum of information required needs to be filled out as the statement of the attending physician.

Refer Complaints to the Medical Advisory Committee

The subcommittee of the Council on Medical Service and Public Relations will act as the medical advisory committee of the WIAA Board. Any complaints as to unfair practices as related to medical care under terms of the program should be referred to the committee through the office of the Secretary of the State Medical Society, 917 Tenney Building, Madison 3, Wisconsin. Before filing a complaint be sure that you thoroughly understand the rules under which treatment is given, the schedule of benefits used, and accepted procedures.

Responsibilities of Physicians in Applications For Continued Competition

When you are attending a student injured in athletic competition you may be asked to verify his application for return to athletic competition. Before giving such verification consult the medical regulations given on the following pages, for these regulations must be complied with if the WIAA is to assume responsibility for further coverage of the pupil. The foremost consideration must be the physical well being of the student, and not his key position on the football team or the community desire to have him "die for dear old Rutgers" in the important game of the year. The attending physician must give sole consideration to the health of the student.

Adequate Premium Rate

Largely at the insistence of the physicians serving on the subcommittee the WIAA is now making a complete actuarial study of its operations to determine a premium rate adequate to meet all benefit payments. Helping with the study are a staff member of the state insurance commission, two experienced insurance officials and officers of the WIAA.

Schedule of Benefits

The following schedule of benefits applies to WIAA coverage, subject to the medical regulations and WIAA Requirements for Participation.

Principal Sum (not to exceed)	$300.00
Entire sight of one eye if irrevocably lost	200.00
Fractured skull with cerebral hemorrhage	100.00
Cerebral hemorrhage	75.00
Fractured skull	50.00
Injured knee requiring surgery	75.00
Ruptured kidney—positive blood in urine	50.00
Ruptured spleen	50.00
Ruptured liver	50.00
Suture of laceration (An additional $1.00 will be allowed for each suture over three)	5.00
Tetanus Anti-toxin	3.00

X-Ray Schedule

Ankle joint, ant.-post. and lat. views	7.00
Arm, humerus, ant.-post. and lat. views	10.00
Chest	5.00

Chest, for pulmonary, cardiac, or rib diagnosis, stereo	10.00
Chest, fluoroscopic	3.00
Clavicle, ant.-post. and lat. views	7.00
Elbow, ant.-post. and lat. views	7.00
Finger	5.00
Foot, ant.-post. and lat. views	7.00
Forearm, ant.-post. and lat. views (radius and ulna)	5.00
Hand, ant.-post. and lat. views	7.00
Hip joint, ant.-post. and lat. views	10.00
Knee joint, ant.-post. and lat. views	10.00
Leg, tibia and fibula, ant-post. and lat. views	8.00
Mandibles	10.00
Maxilla and facial bones	10.00
Nose	7.00
Pelvis, ant.-post. and lat. views	10.00
Semilunar cartilage, both knees	15.00
Shoulder girdle	10.00
Skull, complete and stereo	15.00
Spine, cervical ant.-post. and lat. views	10.00
Spine, dorsal, ant.-post. and lat. views	12.00
Spine, lumbar-sacral, with coccyx, ant.-post. and lat. views	12.00
Spine, entire, ant.-post. and lat. views	25.00
Thigh, femur, ant.-post. lat. views	10.00
Toe	5.00
Wrist	7.00
Fluoroscope Examination	3.00

Dislocations

Carpal bone, one	25.00
Carpal bones, each additional	5.00
Clavicle	25.00
Elbow	35.00
Finger, one	10.00
Fingers, each additional	5.00
Hip	75.00
Knee	50.00
Mandible	10.00
Metacarpal bone, one	20.00
Metacarpal bones, each additional	5.00
Metatarsal bone, one	25.00
Metatarsal bones, each additional	5.00
Patella	25.00
Pelvis	75.00
Rib	15.00
Shoulder	30.00
Shoulder, recurrent or habitual, reduction only	20.00
Tarsal bones, one	40.00
Tarsal bones, each additional	10.00
Thumb	10.00
Toe, one	10.00
Toes, each additional	5.00
Vertebrae, one or more	100.00

Fractures

Cheek bone	35.00
Nose	25.00
Clavicle	35.00
Rib, one	10.00
Ribs, each additional	5.00
Scapula	30.00
Sternum	50.00
Vertebrae, one or more	100.00
Vertebrae, transverse process only	35.00
Pelvis	75.00
Sacrum	50.00
Femur	100.00
Fibula, including Potts' fracture	35.00
Metatarsal bone, one	20.00
Metatarsal bones, each additional	5.00
Patella	50.00
Tarsal bone, one	25.00
Tarsal bones, each additional	5.00
Tibia, including Potts' fracture	60.00
Tibia and fibula	100.00
Toe, one	15.00
Toes, each additional	5.00
Carpal bone, one	25.00
Carpal bone, each additional	5.00
Finger, one	15.00
Fingers, each additional	5.00
Metacarpal bone, one	20.00
Metacarpal bones, each additional	5.00
Humerus	60.00
Radius, or ulna, or both including Colles' fracture	50.00
Aspiration, knee or elbow	10.00
Hospital Benefit	100.00
Medical Attendance, Maximum	24.00
If an injury does not come under the above schedule of benefits but requires treatment by a legally qualified physician or surgeon, not including treatment on the field at the time of play or practice, an allowance will be made with the maximum of	24.00

Medical Regulations . . .

1. The fees stated for fracture and dislocations include reduction, fixation and postoperative cure, but are exclusive of hospitalization allowance and x-rays fees. The maximum allowance for all x-rays shall not exceed the scheduled x-ray benefit.

2. **Fractures not Requiring Reduction:** Incomplete fractures, not requiring reductions, will be paid one-half the benefit for closed reduction. For injuries resulting in fractures not requiring reduction, the attending physician shall determine the length of abstinence from further athletic competition, but in no case shall the time be less than half the time required for injuries involving complete fractures.

3. **Open Reduction for Fracture or Dislocation:** The fee for open operation when this procedure is necessary for reduction and fixation of a fracture or dislocation is that for care of simple fracture or dislocation plus 50 per cent. When surgery is required in connection with medical attendance, an additional benefit not to exceed 50 per cent of the medical attendance allowance will be paid.

4. **Multiple Fractures:** When more than one bone is fractured, the fee will be that for a major fracture plus 50% of the fee listed for each other fracture.

5. A copy of the x-ray report taken of all injuries shall be attached to form No. 2 (Statement of Attending Physician).

6. The amount actually allowed will not exceed the itemized statement filed by the physician which must accompany every request for benefit. The listed amount is the maximum in each case.

7. Anyone wearing orthopedic appliances of rigid construction or having a hernia shall not qualify for benefit.

8. The attending physician shall require form No. 2A (Authorization for Treatment) before treating a student, except in emergencies where the submission of the authorization form is not possible until after initial emergency treatment has been rendered. The authorization form should be filed with the Statement of Attending Physician (Form No. 2).

9. Requests for consultation shall be made to WIAA headquarters on form No. 2B.

10. Local practice shall determine within the maximum the fees for treatments not specified in the schedule.

11. All matters of arbitration shall be handled by the WIAA Board and the Medical Consultants Committee. This committee shall have access to the attending physician's records and x-ray plates, as it pertains to the injury or the disability involved. The Medical Consultants Committee shall act as the arbitrator for the physician participating in this plan with the WIAA Board.

12. Examinations for physical fitness must be made by the family physician except in cases where the Board of Education or the city employs a full time physician for that purpose.

13. Regulations concerning time limitations on specified injuries are as follows:

a. Broken Bones: Any injury involving a broken bone, except those specified below, shall require a minimum of sixty days before competition is resumed, and only then upon a re-examination and a certificate signed by physician.

b. Skull Injuries: Any skull injury, involving concussion with hemorrhage shall require that the student remain out of competition for a full year following injury, and then permitted to resume activity only upon a physician's certificate.
Cases of skull injury where the concussion is minor and does not involve hemorrhage, shall require a minimum of thirty days before competition is resumed, plus a re-examination and certificate signed by the attending physician.

c. Injuries of the knee: Any injury of the knee, involving cartilage or structure of the joint, shall require a minimum of sixty days before participation in athletic activities is resumed, and in no case shall competition be permitted in less than the end of the season in which the injury occurred. Under no circumstances shall a student suffering a knee injury be permitted to re-enter the game in which he suffered injury. Such an infraction of the regulations will absolve the WIAA of any responsibility.

d. Injuries of the nose, hand or foot: Any student suffering a broken nose, bone in hand or foot, shall be withheld from further athletic activity for a minimum of fourteen days, and renewal of activity only upon certification of the attending physician.

e. Injuries of the kidneys: Any injury involving a contusion of the kidney which results in blood in the urine shall require a minimum of thirty days before athletic activity is resumed, and then only upon re-examination and certification by the attending physician.
Any rupture of the viscus requiring surgery would necessitate a full year out of athletic competition, and then only resumed upon re-examination and certification by the attending physician.

f. Injuries of the jaw and cheek bone: Any fracture of the jaw or cheek bone, will require a minimum of sixty days out of athletic competition, and then only resumed upon re-examination and certification of the attending physician.

g. Boils: Any student engaged in athletic competition who has boils shall be withheld from competition until the boils have completely healed, and following an examination of a physician and a statement indicating that healing has been completed and the student is authorized to resume athletic activities.

h. Cuts: Any student suffering a cut laceration and severe abrasion shall be withheld from athletic competition for a minimum of five days, and be allowed to resume athletic activity only upon re-examination and certification by the examining physician.

i. Dislocation—Aspirations: No benefit will be paid for dislocations or aspirations unless the boy remains out of athletic activity for a period of not less than 30 days from date of injury, and then only resumed upon re-examination and certification of the attending physician.

No benefits under terms of the WIAA program will be paid unless certification has been filed indicating that the specific regulations concerning time limits have been covered in cases so listed, and a minimum of five days for any injury for which medical benefits are paid. During this five day period, it is required that the injured student refrain from any form of athletic activity, including practice, scrimmage or actual contest.

Remember These Conditions of Payment . . .

In order to qualify for benefits according to the approved schedule, the physician should assure himself that the:

1. Individual is properly assigned to him for service on Form No. 2A, shown on the following pages.
2. Report of injury has been forwarded to the office of the WIAA within the specified reporting period of 12 days from date of injury. In case the school fails to make proper report within this period the authorization for treatment when submitted by the physician will be accepted if the first certified treatment came within the reporting period.
3. Individual and school have qualified for participation in the benefit plan.
4. The physician should not give approval for return to athletic competition without first consulting the medical regulations in regard to the time limit a player must be restricted from competitive play following an injury.

The WIAA program is being operated along sound lines of administration, and your cooperation in making this program a success is earnestly enlisted. Your medical consultants committee has listed a schedule of benefits, but it is understood (1) that if the cost of services in your community are less than the schedule, you will charge the lesser amount, and (2) if the benefits are inadequately measured by community standards or complications of the case, additional charges may be made direct to the parents.

Simplified Reporting . . .

At the request of your medical subcommittee the WIAA has completely revamped its requirements for authorization and reporting of injuries treated under the WIAA program. The following three simplified forms are used in all cases.

Authorization for Treatment—Form No. 2A

This form is to be filled out in duplicate by the school principal or his agent, the original to be sent with the student to the doctor; and the duplicate to be retained by the principal. The attending physician should require this form before treating a student, except in emergencies where the submission of the form is not possible until after initial treatment has been rendered. This form should be sent by the doctor to WIAA with Form No. 2, the Statement of Attending Physician.

Form No. 2-A

Wisconsin Interscholastic Athletic Association

AUTHORIZATION FOR TREATMENT

_____
(Date)

This is to authorize Doctor _____ to give treatment according to the provisions of the W.I.A.A. Benefit Plan, to _____, student in the _____ school, injured _____.
(Date)

Signed: _____
(Principal or Agent)

Note: This form is to be filled out in duplicate, the original to be sent with the student to the doctor; and the duplicate to be retained by principal or his agent.

Request for Consultation—Form No. 2B

Form No. 2-B

Wisconsin Interscholastic Athletic Association

REQUEST FOR CONSULTATION

_____
(Date)

Doctor _____ requests consultation of Doctor _____ for diagnosis-treatment (cross out whichever does not apply) of _____
(Student's Name)

Claim No. _____.

_____, M. D.

Note: This form should be executed in triplicate, the original to be sent to the W.I.A.A.; the duplicate to the consultant, made out by the attending physician and accompanying Form No. 2; and the triplicate copy kept by the referring physician.

Statement of Attending Physician—Form No. 2

This form is to be filled in by the attending physician with specific information as to the examination, diagnosis and treatment and the bill for services rendered. If x-rays were taken a copy of the report should accompany this form. In all cases, the authorization for treatment brought to the doctor by the student should accompany this form to the WIAA.

Wisconsin Interscholastic Athletic Association

_____
(Date)

Name _____ Address _____

School _____ Age _____ Date of Injury ____ Place of Injury _____

_____

(To be filled in by attending physician)

Statement of Injury:
(To include date, time of injury and activity engaged in at time of injury.)

Examination: (Describe accurately)

X-Rays: (Report)

Diagnosis:

Treatment: (Please be specific)

Disability:
Can student continue school? _____ If not, when? _____
Is further treatment necessary? _____ Office _____ Home _____ Hospital _____
(State number of visits in each case.)

Statement:

Date	Services Rendered	Amount

_____ M. D.

_____
(Address)

_____
City Zone State

Parents Told About WIAA . . .

Publicity concerning the WIAA program has always emphasized that the program is not a full-coverage, all-inclusive plan. Present publicity is more specific on this point and should do a great deal to correct the misimpression that the benefit program was the form of insurance which freed the parent from any responsibility to the attending physician in the care of the student. Below is an example of publicity now being circulated to parents and others.

1948 W.I.A.A. 1949

ATHLETIC ACCIDENT BENEFIT PLAN INFORMATION

FOR

PARENTS AND OTHERS

All who participate in the Benefit Program of the W.I.A.A. are entitled to certain benefits in event of injury. This leaflet attempts to inform parents of participants as to such benefits. The W.I.A.A. Benefit Program is not an insurance. The plan is definitely non-profit. The program intends to assist in meeting cost of injuries which occur in connection with the educational program. The W.I.A.A. does not guarantee full payment of medical costs—neither does any other similar plan.

The benefits compare favorably with those of other medical service programs costing substantially more. The benefits in a large majority of instances represent the entire amount charged by the physician, dentist or hospital.

The State Medical Society of Wisconsin, through a consultants committee is assisting the Wisconsin Interscholastic Athletic Association with the medical aspects of the program. The benefits have been keyed to the income of the Wisconsin Interscholastic Athletic Association, and provide a major portion of the total cost of care. However, it should be clearly understood by all those covered by the program of the W.I.A.A. that the Benefits provided may be supplemented by additional charges by those caring for the patient. Many physicians of the State render service to W.I.A.A. patients in accordance with the schedule of benefits, but with the understanding that additional charges may be made direct to the parent in case the injury is of such a nature as to require exceptional care.

In the event of injury, the physician of your choice will be paid for his services in accordance with the schedule of benefits, but you, as a parent, may be billed an additional sum to provide a total payment somewhat related to customary charges for the services rendered if the scheduled fee does not fully compensate.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

Leukemoid Reactions of the Myeloid Type

The purpose of this presentation is to call attention to an interesting classification of leukemoid reactions of the myeloid type proposed by Hill and Duncan in 1941.[1] This classification (table 1), evolved as a result of a study of many cases observed at Baylor Hospital in Dallas, Texas, includes a wide variety of diseases and clinical conditions and groups them according to apparent causal mechanisms. It is not claimed by the authors that the conditions listed in the classification are constant producers of leukemoid pictures; in fact, most of them are the exception rather than the rule. Actual diagnosis and differentiation of a given case from true leukemia may be very difficult, but the careful weighing of all clinical features and certain laboratory findings should help the observer in arriving at a correct diagnosis in many instances.

TABLE 1

I. Bone marrow irritation or stimulation: This may be physical, chemical, or allergic in character.
   A. General features of blood picture
      1. High leukocyte count, often over 75,000
      2. Eosinophilia and basophilia frequently prominent
      3. Degree of leukocyte immaturity less marked than in II and III; usual myelocytes with few or no myeloblasts
   B. Conditions or diseases capable of producing this type of reaction
      1. Osteomyelitis and complicated bone fractures
      2. Metastatic carcinoma of bones
      3. Chronic infectious granulomata of bone
      4. Hodgkins' disease with bone marrow lesions
      5. Severe reactions to intravenous medication
      6. Severe reactions following transfusions
      7. Pyogenic infections

II. Liberation leukocytosis; Marrow response to overwhelming demand
   A. General features of blood picture
      1. Leukocyte count variable, usually less than in group I
      2. No definite eosinophilia in most cases
      3. Degree of leukocyte immaturity generally greater than group I
   B. Conditions or diseases capable of producing this type of reaction
      1. Acute hemolysis in:
         a. Sulfanilamide therapy (and related drugs)
         b. Familial hemolytic anemia
         c. Blackwater fever of malaria
         d. Sickle cell anemia
         e. Hemolytic poisons, phenylhydrazine, and so forth
      2. Erythroblastic anemia
      3. Pernicious anemia in crisis
      4. Following severe hemorrhage
      5. Recovery phase of granulocytopenia
      6. Polycythemia, especially in anemic phase such as following therapy
      7. Septicemia
      8. Stage of impending death in acute infections

III. Ectopic hematopoiesis: Formation of blood-producing foci outside of bones, usually due to destruction or crowding of bone marrow
   A. General features of blood picture
      1. Leukocyte count relatively lower, often in normal range
      2. Eosinophilia not prominent
      3. Degree of leukocyte immaturity more marked than in groups I and II
   B. Conditions or diseases capable of producing this type of reaction
      1. Osteosclerosis and osteofibrosis
      2. Prolonged increased demand in
         a. Chronic form of familial hemolytic anemia
         b. Prolonged untreated pernicious anemia
      3. Tumors with extensive replacement of bone marrow
      4. Lipoid histiocytosis

Hill and Duncan have found certain other hematologic features of help in the differentiation of leukemoid pictures from the leukemia. These are presented in table 2.

TABLE 2

Leukemoid Picture	*True Leukemia*
1. Immature as well as mature leukocytes show normal morphology.	1. Leukocytes are atypical, particularly the immature ones.
2. Myeloblasts may be present, but usually are under 10 per cent.	2. Myeloblasts may be numerous, as high as 99 per cent.
3. Immature red cells (normoblasts and erythroblasts) often increased in proportion to leukocyte immaturity.	3. Immature red cells rarely increased in proportion to leukocyte immaturity.
4. Platelets usually normal or increased; may be moderately decreased in group III (table 1).	4. Platelets decreased, often severely; usually increased in chronic myelogenous form only.
5. Anemia variable depending on causal factors.	5. Steadily progressing anemia, becoming extreme.

It seems worth while to emphasize that tuberculosis, septic infections, and carcinoma especially have frequently been reported as being associated with a leukemoid blood picture. Scattered reports are available concerning atypical blood pictures with osteosclerosis and extramedullary foci of hematopoiesis in various organs.—WALTER H. JAESCHKE, M. D.

REFERENCE

1. Hill, J. M., and Duncan, C. N.: Leukemoid reactions, Am. J. Med. Sc. 201:847–857, 1941.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

C. K. LUCHTERHAND

Mr. Luchterhand, a native of Calumet County, studied at the University of Wisconsin, where he completed three years of pre-medical courses before transferring to the field of dairying.

He served Wisconsin as a state dairy inspector for two years before joining the State Health Department in March 1944.

The Need for Properly Pasteurized Milk Supplies

The past ten years have seen a tremendous increase in milk consumption and appreciation of the nutritive value of milk. The assurance of a milk supply which is adequate, safe, and palatable is one of the three great environmental sanitation problems that must be considered by every family municipality, and the physicians whose role it is to safeguard the health of the citizens.

The author of an outstanding book dealing with the public health aspects of milk sanitation states that, "the safety of a community's milk supply is in direct proportion to the percentage of properly pasteurized milk consumed and since the sanitarian must devote his energy to milk safety, pasteurization is the surest way of attaining it."

These words contain considerable merit and can be used as an inspiration for physicians, health officers, and sanitarians throughout the state of Wisconsin. Our goal should be the proper pasteurization of every drop of fluid milk sold in cities in the state of Wisconsin. Whether the job is done by compulsion or otherwise, the fact still remains that a considerable amount of educational work is still necessary. This burden cannot be borne by one individual, one agency, or one city, but must be a cooperative effort on the part of all people interested in the health and welfare of the citizens of Wisconsin.

Pasteurization in Wisconsin

In order to obtain a bird's-eye view of the pasteurization situation in the state insofar as local legislation is concerned, a card survey was carried out some time ago of all the incorporated municipalities in Wisconsin.

In summarizing the results of the card survey, briefly, we find that of the 479 communities reporting, 172 have some form of milk ordinance, of which 78 are ten years or older and have not been brought up-to-date; in fact some are licensing ordinances only; 39 required compulsory pasteurization at the time of the survey; 80 communities depended upon local enforcement either through a milk sanitarian, who in some cases was on a part time basis, or by the local health officer. In the last instance we can see where it might be rather difficult for a practicing physician, working on a part time basis as health officer, to make continuous routine inspections and take samples. Seventy-four communities had local enforcement by the health officer and were also dependent upon the state for help. Eighteen of the communities having some form of milk ordinance were solely dependent upon the state for help. This means that 307 communities had no ordinances and 325 were solely dependent upon the state for some sort of control over the local milk supply, which is just barely scratching the surface! Fifteen Wisconsin cities have now adopted the Standard Grade "A" Ordinance as recommended by the United States Public Health Service. Thirty-four comunities failed to report, and to date we have been unable to follow up with personal calls. It would be safe to say all of these would fall into the low population bracket of 150 to 3,000 and it might be said that none have milk ordinances.

You will note that the foregoing statistics survey indicated that at the time of the survey 39 Wisconsin cities required compulsory pasteurization. Since that time a number of cities have been added to the list, and our latest figure is now 43. These municipalities have realized that pasteurization is the only known method which, if properly applied, *will* safeguard all milk supplies from pathogenic infections. The one thing that differentiates pasteurization from all other protective measures is that, while all other measures may fail to protect completely even if they are properly applied, pasteurization will always protect if it is properly applied. *No milk-borne epidemic* has ever been traced to properly pasteurized milk. Pasteurization is no substitute for sanitary practices in production of milk. *Both* are necessary for a safe, clean milk supply.

Recent reports from the State Department of Agriculture indicate that 94 per cent of all fluid milk sold is now pasteurized. Figures from the United States Public Health Service show that the percentage of milk supply of American municipalities of 10,000 and over which is pasteurized is rapidly increasing, but, as in Wisconsin, the actual number of municipalities in which the pasteurization of all market milk is compulsory is still rela-

tively small. This means that in a large number of American cities a certain amount of milk, other than certified, is being sold raw, that is, it has not been protected by every reasonable precaution known to the public health profession.

Intercommunity Programs

In looking over these figures, we can see that there is still a considerable amount of work which can be done. In the cases in which communities are too small to afford a complete milk control program, the cooperative milk control program among a number of communities is the answer. In this manner a community can have inspection and laboratory service at the price of only a few extra quarts of milk per person per year. The State Board of Health has been working with this type of program for the past three years and will assist communities interested in setting up this type of program. Where milk ordinances are out-dated or lacking, the adoption of the Standard Milk Ordinance recommended by the United States Public Health Service should be considered. It is a good ordinance, designed to protect public health insofar as milk is concerned, and attention is directed toward uniformity, something we have not had too much of in the past. This ordinance can also be adopted by reference in the short form, so that the objection of many communities to the cost of printing a long milk ordinance is easily overcome.

Getting the Facts to the City Fathers

In adoption of any legislation, education is paramount, and if thorough preparation has been made by the local health officials and clearcut convincing arguments are presented to local legislative bodies, the probability that the ordinance will be adopted is good in the majority of the cases. Even though some of this legislation may not go through as expected, and the outlook is discouraging, this should not be a deterrent to the objective of a safe milk supply. Health officials must realize that promotional and educational work can go forward even though the needed legislation is lacking.

Local health officials may ask, "What can we do about pasteurization? We know that only *properly pasteurized* milk is *safe milk*, but we have raw milk dealers still in business and certain consumers still asking for raw milk." The proper answer to these questions is still the fundamental fact that educational activities offer the health official and physician unlimited possibilities, and many a successful milk program has had as its foundation a sound educational approach. We must not forget that the basic objective of a milk program is the increased use of properly pasteurized milk. This can be done by publicity, vigorously advocating the pasteurization of the communities' milk supply. The health officials who adopt the status quo attitude will do little toward bringing about universal pasteurization. A firm stand is necessary on an issue of such magnitude, and all reasonable efforts should be directed toward it.

To reach a goal of this magnitude requires the cooperation of all interested parties. The medical profession plays a salient part in promoting this program. The State Board of Health depends upon the profession for support in this worthwhile venture; first, to increase consumption of milk in Wisconsin communities, and second, to see to it that all such supplies are properly safeguarded.—C. K. LUCHTERHAND, *Milk Sanitarian.*

President of the State Medical Society of Wisconsin

(Picture on opposite page)

Dr. Karl H. Doege, 1948 president of the State Medical Society, was born in Marshfield in 1892. He received his bachelor of science degree from the University of Wisconsin prior to entering Johns Hopkins University School of Medicine, from which he graduated in 1917. Following internship at Bayview Hospital in Baltimore, he served as a medical officer in the United States Army during World War I. At the end of the war, he located in Marshfield, where he has served on the staffs of the Marshfield Clinic and St. Joseph's Hospital. In 1924 he spent six months in Europe in postgraduate study.

The doctor has been a fellow of the American College of Physicians since 1931. In 1937 he was certified by the American Board of Internal Medicine. He is also on the intramural teaching staff of the University of Wisconsin Medical School, serving as preceptor-in-chief at Marshfield, where he trains fourth year students.

Medical editor of *The Wisconsin Medical Journal* since 1939, Doctor Doege was appointed to the Council on Scientific Work in 1941. He has been a delegate to the State Medical Society from Wood County for the past ten years, and for eight years prior to that time he served as alternate delegate. From 1941–1947 he was chairman of the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws. In 1935 he was named president of the Wood County Medical Society.

Karl H. Doege, M. D.
President, State Medical Society of Wisconsin

As It Looks From the County Judge's Office

JAY H. GRIMM

A native of River Falls, Judge Grimm was admitted to practice law in 1900. He served as assessor of incomes from 1911 to 1922 and as a member of the Board of Regents of Normal Schools from 1928 to 1941. Since 1941 he has been County Judge of Pierce County. Judge Grimm, a member of the Board of Governors of the Wisconsin Bar Association, is chairman of a committee of the State Board of County Judges for Homes for the Aged Infirm.

Many of the problems of the county judge come at the beginning and at the end of life, juveniles under 18 and the aged and infirm who are over 65. Many parents do not take the proper care in the raising of their children; they want to live their own lives without the responsibilities of parenthood. They spend too much time in taverns and such entertainment, thereby neglecting their children. They sometimes lock them in the house while they are away, sometimes leaving them to roam the streets alone until very late into the night. At the other end of life the children are more and more neglecting their parents. They do not want the responsibility of taking care of old people. In my youth it was a disgrace if children did not take proper care of their aged parents, but this idea seems to be passing, and the children now want to throw all this responsibility onto the public. The trouble finally comes to the County Judge and Welfare Department.

A few years ago I became very much alarmed at being required to send so many seniles to insane asylums. So many of them were returned for burial within a few weeks or months that I felt as if I were signing their death certificates when I signed the commitment. I took the matter up with Dr. Charles A. Dawson of River Falls, who was then president-elect of the State Medical Society. He also felt that something should be done about it. We agreed that he would take the matter up with the State Medical Society and that I would take it up with the Board of County Judges and we would see if we could get legislation providing for county infirmaries to take care of these old people. When I took the matter up with the Board of County Judges I was surprised at how one judge after another arose and talked in favor of legislation to correct this evil. Committees were appointed by both the Board of County Judges and the State Medical Society. The State Medical Society has borne the brunt of the work. The bill was presented to the last legislature too late for action, but we are hoping to get it enacted during this session. Most of the doctors of the state know about this bill and are supporting it.

The business of life is a game we play. It is the greatest game of our lives. We play to win, but win or lose we must get our pleasure in life out of our work, or we will never know what pleasure is. For most of the people who come before us, the great game of life is over. Most of them have lost. Some were for a time successful, but time and circumstance changed all for them. Many of them have no hobby and some of them do not even read. They have little to interest them or occupy their time, little to look forward to. They are pathetic. Many who have been successful in accumulating money find themselves in the same position. No one wants them and there seems to be no place for them. The county infirmaries provided for in the bill will pretty much take care of this problem.

I find that the county judge has to consult with one or more doctors very often before making his decisions. In sending people to the State of Wisconsin General Hospital for treatment, they must first be examined by a doctor. In determining cases of insanity or

(Continued on page 1015)

The
MEDICAL FORUM

The Wisconsin Medical Journal — October, 1948

TRUITT IS PRESIDENT-ELECT OF MEDICAL SOCIETY

HOUSE OF DELEGATES ACTS ON MERGER OF MILWAUKEE, STATE PREPAID PLANS

Milwaukee, Oct. 5—The Reference Committee on Resolutions considered proposals offered by Dr. H. H. Christofferson, Colby, and Dr. J. W. Truitt, Milwaukee, and after conferences with officials of the Medical Society of Milwaukee County referred the following resolution to the House of Delegates where it was adopted unanimously:

"Whereas, numerous attempts to consolidate Wisconsin Physicians Service and Milwaukee Surgical Care into one state-wide plan have failed, and

"Whereas, a final attempt, made by this committee yesterday afternoon also failed, and

"Whereas, in October, 1946, this House of Delegates withdrew its approval of Milwaukee Surgical Care as of November 30, 1946,

"Be It Therefore Resolved that the State Medical Society of Wisconsin notify the Insurance Commission of Wisconsin that Milwaukee Surgical Care is no longer operating in a manner approved by the State Medical Society of Wisconsin, and

"Be It Further Resolved that the State Medical Society of Wisconsin expresses willingness to receive from the Medical Society of Milwaukee County overtures relative to the consolidation of the two plans, which may be transmitted to the Council of the State Medical Society at any time."

J. W. TRUITT, M. D.

Annual Meeting Highlights

The House of Delegates approved the action of the American Medical Association in disapproving the formation of a National Health Insurance Company under the auspices or direction of Blue Cross–Blue Shield.

* * *

Recommended that the State Medical Society request the Governor to establish a state-wide committee for civilian defense and disaster plans, the medical aspects of which will be coordinated by a State Medical Society committee.

* * *

Stated that all young physicians of the specified age and training with no previous military service and those who received all or part of their medical education at the expense of the government under ASTP or V-12 programs have a moral obligation to volunteer for military service as soon as possible.

Voted to establish a program with the legal profession to insure proper expert medical testimony in court cases.

Doege Takes Office As President; Elect 5 New Councilors

Milwaukee, Oct. 5 — Dr. J. W. Truitt, Milwaukee, was named president-elect of the State Medical Society of Wisconsin at the 107th anniversary session of the Society here. He will take office at the next meeting of the Society in 1949.

Dr. Truitt, a Councilor and member of several important medical society committees, will succeed Dr. Karl H. Doege, Marshfield, who took office on Oct. 5.

Dr. Gunnar Gundersen, La Crosse, was re-elected speaker of the House of Delegates, and Dr. R. L. MacCornack was elected vice-speaker.

Dr. S. E. Gavin, Fond du Lac, and Dr. J. C. Sargent, Milwaukee, were reelected to serve as delegates from Wisconsin to the American Medical Association. Alternate delegates, Dr. L. O. Simenstad, Osceola, and Dr. D. H. Witte, Milwaukee, were re-elected.

When informed of his elcction as president-elect, Dr. Truitt stated "I shall give my best efforts to hasten the expansion of health insurance to all the people of the state and for harmony among the medical profession."

Five physicians will serve on the State Medical Society Council, governing body of the Society between sessions of the House of Delegates, for the first time in the coming year. They are Dr. Gustave Eck, Lake Mills; Dr. N. J. Wegmann, Dr. R. E. Galasinski and Dr. T. J. Howard, Milwaukee, and Dr. H. E. Kasten, Beloit. Drs. T. C. Hemmingsen, Racine, and V. E. Ekblad, Superior, were re-elected as Councilors.

IMPORTANT NOTICE

Change of Address for Veterans Agency and WPS

704 EAST GORHAM ST.

The Wisconsin Veterans Medical Service Agency of the State Medical Society headed by Mr. Thomas J. Doran, and the Wisconsin Physicians Service headed by Mr. Ralph F. Weber, have completed the transfer of their offices to the new society headquarters at 704 E. Gorham St., Madison.

Hereafter, all correspondence with these agencies is to be addressed to that number.

Special Committee Praises Board of Health in Report to State Legislative Council

64-Page Report Disagrees with Griffenhagen Study; Recommends Several Changes

Madison, Sept. 14.—A special technical committee appointed by the State Medical Society of Wisconsin to make a study of the State Board of Health turned in a highly complimentary report on the board's organization and operation.

The 64-page report represented a 6-month study made at the request of the state legislative council in light of recommendations made in a report by Griffenhagen & Associates, public service analysts, nearly two years ago.

Members of the committee were Drs. H. Kent Tenney, Madison, chairman; C. D. Neidhold, Appleton; W. W. Bauer, Chicago, and Gaylord Anderson, Minneapolis. Dr. R. G. Arveson, Frederic, and C. H. Crownhart, secretary of the medical society, were ex-officio members, and Martin W. Torkelson, Madison, director of the state planning board, and W. W. Cary, Milwaukee, secretary of the board of trustees of the Northwestern Mutual Life Insurance Co., were called in as technical advisors.

"Model Legislation"

Terming the law for the organization of the State Board of Health "model legislation," the committee expressed strong approval of the present law providing for the appointment of members of the state board.

The committee said the present method placing no restrictions on the Governor other than Senate confirmation, avoids the appointment of individuals representing "special group interests" who would tend to be "protagonists of the group they represent rather than to recognize 'public health' as the responsibility of all."

Sharp disagreement was expressed with a suggestion made by Griffenhagen that the state health officer be appointed by the Governor instead of through a board of health as he is now. The present method assures security of tenure to competent health officers and at the same time permits necessary changes.

Several immediate changes were recommended by the medical society committee:

H. K. TENNEY.

ONE—Nurses have sufficient numbers and professional status to warrant the establishment of a new and distinct state department of nursing.

TWO—Additional space for the Board of Health is needed.

THREE—There is urgent necessity for legislation permitting construction of a building to house the State Laboratory of Hygiene on the University campus near the medical school.

FOUR—An administrative assistant should be provided to assist the state health officer in business and procedural responsibilities.

FIVE—A law to provide grants-in-aid to counties for the establishment of local health departments is needed if more rapid progress in public health activities is to be accomplished.

SIX—Revision of the statutes is needed to make the committee of examiners in funeral directing and embalming an advisory committee rather than a body with equivalent status to the State Board of Health.

Consolidation Begun

The committee pointed out that many of the suggestions for improvement in the work of the State Board of Health mentioned in the Griffenhagen report as well as the corrections proposed had been called to the attention of Griffenhagen investigators by State Board of Health personnel two years ago. Many changes were under way at that time and considerable progress has been made since then.

New pay scales have helped the board fill long vacant positions; lines of authority and responsibility have been cleared; organizational structure has been revised; all phases of health education work are being consolidated; and economies in office procedure have been achieved through the use of form letters, central mailing and standardized methods.

Praise Board

A suggestion that the various "bureaus" and "division" of the board be uniformly named was rejected by the committee. Such a change would involve major reorganization of the statutes and the benefits would scarcely justify the effort, the committee said.

Contrary to the Griffenhagen report the medical society committee saw no reason to change the relationship between the University and the State Board of Health in the operation of the State Laboratory of Hygiene. Likewise, it felt that the State Board of Health is not over-staffed if it is to meet its responsibilities for the protection of the health of the public.

The responsibilities and opportunities for public health progress in the light of modern medical and allied sciences are so great that they are not being met adequately anywhere, the committee stated, but "within the legislative and budget limitations now existing, the committee finds that the Wisconsin State Board of Health has functioned with exceptional effectiveness and that it is handicapped by vacancies among professional personnel in the public health field due to a nationwide shortage of such personnel."

WOOLSEY NAMED TO NEW PROFESSORSHIP AT U. W.

Madison, Sept. 6.—The University of Wisconsin Medical School has announced the appointment of Dr. C. N. Woolsey as Slichter Research Professor of Physiology. This is a newly created professorship established by the Wisconsin Alumni Research Foundation.

Dr. Woolsey was formerly with Johns Hopkins University school of medicine in the field of physiology and neurophysiology. In 1938–39 he had an appointment as Rockefeller fellow at Eldridge Reeves Johnson Foundation for Medical Physics. He has contributed extensively to scientific literature.

Parent-Teachers Announce Health Program: Suggest Local Action Committees

Washington, D. C., Sept. 15—The National Congress of Parents and Teachers recently announced that "health" is one of its specific points in its current four-Point Program and has outlined the problem, general principles and suggested actions which local units should take in the matter.

Four Projects

Four basic projects have been outlined for local P.T.A. groups in all communities:

1. Cooperate in every way possible with public health departments to intensify and expand local health services and facilities and spread sound health information.

2. Install in students and parents an understanding of the modern changes that have taken place in the professions of medicine, nursing, dentistry and allied health fields and point out to them the advantages of careers in the fields of health.

3. Study and evaluate community provisions for maternal and infant care; prenatal clinics, hospital and nursing facilities, well-baby clinics and the like; and with the advice of local health officers promote action to expand the services necessary to safeguard the physical and mental health of children and adults.

4. Survey community provisions for the care and education of the physically handicapped, mentally deficient, emotionally troubled and the gifted.

The P.T.A. urges that local units "support all approved health legislation—including measures providing the maternal and child welfare appropriations for the survey and construction of hospitals and provision for other public health service." Other projects urged by the P.T.A. are to plan forums and discussions on health matters, study the possibility of setting up scholarships for careers in the field of health, promote summer round-ups of children to see that remediable defects are discovered and corrected promptly and to do everything possible to improve health conditions in their respective area.

ARMY AND NAVY EXPAND TRAINING PLANS TO BOOST ENLISTMENT OF MEDICAL MEN

Washington, D. C., Sept. 21—The Army and Navy recently announced expansion of their professional training programs for reserve and regular medical officers, with the twofold purpose of permitting more doctors in service to meet specialty board requirements and at the same time encourage young doctors to affiliate with the armed forces.

Five major aspects of the training program for Army and Reserve Medical officers are described by the Surgeon General as follows:

1. The Army Medical Corps has extended until November 1 its time limit for medical school graduates to apply for commissions under the Civilian Resident and Intern Training Program. Under the program selected individuals serve out their internships and residencies in civilian hospitals of their choice—receiving full pay and allowances for their rank, plus $100 a month professional volunteer bonus.

Upon completion of their year's training interns must apply for regular commissions and may qualify for residency training. Residents may continue their training with a view to certification by specialty boards.

Officers who participate in these programs are expected to serve a year of active duty for each year of training they receive.

2. Active reserve service for specified physicians and limited periods will be offered doctors who are not interested in a regular Army career.

The Surgeon General of the Navy has announced a similiar program:

1. Interns and resident physicians in civilian hospitals are now eligible for commissions in the regular Navy, but will be permitted to continue their training while receiving all the pay and allowances of their rank.

Interns under this program must remain on active duty for a period of one year upon completion of their internship. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event of an emergency.

The Navy has at present more than 400 approved residencies and fellowships in the various specialties in naval and civilian hospitals. One hundred of these residencies are reserved for civilian physicians accepting commissions in the regular Navy.

PLAN REVISION OF HIPPOCRATIC OATH

London, Eng., Sept 20.—Wartime atrocities may lead to a revision of the Hippocratic oath which doctors have taken for centuries, Dr. Charles Hill, secretary of the British Medical Association said after a recent meeting of the World Medical Association.

Medical associations throughout the world will be polled before the change is finally decided upon, he said. The change was suggested after the medical profession learned of the appalling crimes committed by German doctors under Hitler.

YOU ARE 100 YEARS OLD BUT ONCE

Wisconsin is making the most of its first 100 years of Statehood—giving recognition to its sons and daughters, its industries and professions—all of the things that have made Wisconsin a great State.

The practice of medicine in Wisconsin has more than kept pace with the rest of the world. The medical profession, together with the economic standards of Wisconsin, has made Wisconsin a healthy place to live.

Our business brings us in close contact with the medical practitioners of Wisconsin, and to this profession may we convey our thanks for your part in developing this great State during its first 100 years.

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WOOD RESIDENTS PRESENT "THE IMAGINARY INVALID"—Cast of characters (l. to r.): Carroll R. Olson, M. D., Thomas Diafoirus; Virgil E. Seibert, M. D., Angelique; Robert L. Paver, M. D., Cleante; Eugene F. Brandt, M. D., Monsieur Diafoirus; Julius M. Meyer, M. D., Argan; Jack J. Levin, M. D., Fleurant; Maurice Hardgrove, Monsieur Purgon; Matthew W. Monroe, M. D., Toinette, and Bertram H. Dessel, Beralde.

RESIDENTS AT WOOD PRODUCE PLAY AT MEDICAL MEETING

Milwaukee, Sept. 1—The medical residents of Wood Hospital recently presented "The Imaginary Invalid", a play by Molière. The play was in the evening, and followed a day of scientific papers presented by the residents.

The play is a satire on the false dignity of some physicians of the 18th Century. It also makes great fun of the hypochondriacal patient and his problem.

Cultural development of the younger physicians proceeds along the lines of interest outside of the practice of medicine.

Hennessy is New Secretary of NEMS

Chicago, Sept. 6—Dr. Harold R. Hennessy, who has been associated with the AMA Council on Industrial Health since February, 1946, has been assigned as full time secretary of the AMA Council on National Emergency Medical Service headed by Dr. James C. Sargent of Milwaukee. The flood of work which is facing the council made necessary the creation of the office which Doctor Hennessy will occupy.

He received his M.D. degree from the University of Minnesota and held various assignments during the war years, his last being that of head of the public health section in the office of the Surgeon, Fifteeneth U.S. Army.

Crownhart on Governor's Committee to Employ Handicapped Persons

Madison, Sept. 14—Governor Rennebohm has named a permanent committee to study employment problems, of the state's physically handicapped persons.

Mr. C. H. Crownhart, Secretary of the State Medical Society, was among the persons named to represent labor, industry, business, veterans, the professions and the public on this committee. Mr. Harry Lippart, director of the Wisconsin State Employment Service, was named chairman.

The Governor said that it was hoped that through the actions and recommendations of the committee employment of physically disabled persons could be increased.

Second Meeting of "50-Year Club" Honors Eighteen Veteran Physicians at Milwaukee

Recipients of Pins Express Their Gratitude; More Than 80 Members

Milwaukee, Oct. 5—Eighteen veterans of Wisconsin medicine were honored at the second annual meeting of the "50 Year Club" held during the 107th Anniversary meeting of the State Medical Society.

They were the newest members of the "50 Year Club", their membership becoming effective at the meeting. A "50 Year Club" member must have served his community in the practice of medicine for at least half a century to become eligible for membership. This year eighteen physicians were added to the list of 75 members so honored at the first meeting of the club. They were:

William Hipke, Marshfield; R. S. Ingersoll, Plainfield; Joseph Lettenberger, Milwaukee; G. W. Lueck, La Crosse; T. E. Malloy, Random Lake; V. F. Marshall, Appleton; P. R. Minahan, Green Bay; E. M. Poser, Columbus; G. R. Reay, La Crosse; W. W. Stebbins, Madison; C. R. Treat, Sharon; A. F. Young, Milwaukee; J. S. Madison, Milwaukee; G. E. Bilstad, Cambridge; H. H. Williams, Sr., Sparta; F. S. Wiley, Fond du Lac; G. H. Irwin, Lodi; W. H. MacDonald, Lake Geneva.

Each member of the club receives an engraved "50 Year Club" pin and certificate commemorating his many years of service. The following are excerpts from many of the letters received from recipients of the "50 Year Club" award:

"I prized the lapel pin very highly and shall be proud to wear it."

"The symbol of faithful service in treating human ailments is a beautiful remembrance and I wish to express my sincere thanks to you."

"Thank you very much for the '50 Year Club' pin. I will wear it with a great deal of pride."

"I wish to thank the Society for the handsome lapel pin and kind letter accompanying it. It is enough to know in my heart that I have done as good a job as possible in my chosen field. To have the public and concrete acknowledgment of it from the State Medical Society makes my satisfaction doubly complete."

"The '50 Year Club' pin is one of my prized possessions and will be worn constantly from this time on."

"Thank you for the pin evidencing membership in the '50 Year Club'. It is always nice to receive recognition from one's fellows, even if for nothing more than having plodded along for 50 years as a general practitioner."

"The State Medical Society deserves the utmost thanks of the club for dedicating these tokens of esteem, and I assure you the pin and letter will be preserved by me and my family for many years to come."

COMMENTS FROM THE WISCONSIN PRESS

The issue of voluntary health insurance versus compulsory sickness insurance has been the subject of endless writings for more than half a century. In recent years the debate has become more intense. The following comments represent the editorial viewpoint of several Wisconsin newspapers.

"Socialized medicine, of course, is not the answer to the problem in this country. Private enterprise, if so-called liberals will permit the use of that expression, can meet the problem of better and more widespread medical attention . . . —Marinette Eagle–Star, Sept. 14, 1948.

* * *

"It is hard to see how a (national) health program could be set up and operated successfully without the approval and active aid of the medical societies. Therefore it would seem to be common sense for the advocates of the program to consult with responsible leaders of the profession with a view to removing the obstacle of professional opposition . . . Surely no sincere doctor can disagree with the fundamental aim of better health. Surely also the opinions of medical people on how to achieve this aim have value."—Kenosha News, Sept. 13, 1948.

* * *

"Socialized medicine, or the 'health program' as the politicians like to call it, would most likely destroy progress in medical science as it would promote the politician and the quack, anyone who could worm himself into a position of power. Simultaneously it would deaden the brains of the competent who could expect nothing for their brilliant efforts except to see another medal pinned on the expansive chest of their political superior. As a class medical men are aware of this menace, this proposed step back into the shadows of graft and ignorance."—Appleton Post–Crescent, Sept. 14, 1948.

* * *

"Socialized medicine, the proposed national 'Health Program,' would probably deaden individual initiative as it advanced extolled the bumbling flannel-mouths. Most of our great scientists are poor speech makers and poorer conspirators. They wouldn't last long with a guy from Idaho playing a guitar or Vito Marcantonio shaking hands with some New York assassins."—The Green Bay Press–Gazette, Sept. 17, 1948

* * *

"More evidence has come from New Zealand, whose governmental medical program was much praised in this country when it went into effect. The bill for tax-paid medical service rose nearly three times between 1942 and 1947. Even though the politicians had promised unlimited benefits to the voters, they were forced to ask the doctors to restrict services to their patients—a request which the doctors have refused to follow."—Shawano Journal, Sept. 16, 1948.

* * *

"The Truman plan, as we see it, will ultimately amount to socialized medicine with the health of the nation placed almost directly in the hands of a paternalistic government which is steadily endeavoring to gain more and more power over the lives of the citizens . . . Most of our economic troubles of today, including inflation, are due to the burden of an overgrown government. The Truman plan would enormously increase that burden."—Portage Register–Democrat, Sept. 4, 1948.

* * *

"In the case of an inclusive socialized health care plan, the opportunities (for cheating and waste) are practically limitless.

"The problem before Americans is to find a means of bringing good health care within the reach of the thousands now deprived of it—and quickly—through an American system that will not be subject to the flagrant abuses, the waste, the red tape and the bureaucratic controls inherent in an inclusive system of socialized medicine."—The Milwaukee Journal, Sept. 19, 1945.

DOCTORS INVITED TO NURSING INSTITUTE

The Committee on Nursing Education, Wisconsin State Board of Health, announces a two-day Institute on "Changing Concepts of Nursing" to be held at the Plankinton Hotel in Milwaukee on November 12 and 13, 1948. Representatives of the State Medical Society of Wisconsin, the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals and the Wisconsin State Nurses Association have served as members of the planning committee. Detailed information will be released in the near future.

4-H Club Members Attend Health Camp on Medical Society Scholarships

Madison, Sept. 15—Eight 4–H Club members and leaders attended the state 4–H Health Camp at Green Lake, Wis. from Sept. 8 to 11 on scholarships provided by the Committee on Rural Health of the State Medical society. Each year the committee provides scholarships for a certain number of club members who have achieved excellence in 4–H Club health activities. While there they participate in health lectures, exhibits and demonstrations under the supervision of 4-H leaders and state health personnel.

Eight Winners

The persons receiving the 1948 scholarships are: Dale Rood, Viroqua; Murray Sandleback, Green Lake; Dorothy Fritsch, Antigo; Donna Weiland, Kendall; Allegra Jostad, Holmen; Mrs. Carl Rasch, Hales Corners; Dorothy Westfall, Vesper; and Joyce Lampheer, Glenbeulah.

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Practical Nurses Trained at Milwaukee Vocational

Have Room for More Students; Graduates Licensed; Plenty Jobs

Milwaukee, Sept. 8.—A twelve-month course to train attendants or practical nurses to assist in general nursing care in hospitals or homes got under way recently at the Milwaukee Vocational School, according to Miss Hattie E. Anderson, faculty counselor, division of nursing education. Part of the training is given at St. Michael's hospital and the Milwaukee County institutions.

Need More Nurses

Practical nurses need to be trained in large numbers if the present standards of nursing care for the American people are to be maintained. This course, like another being offered at the Kenosha Vocational School, is designed to prepare practical nurses to perform routine bedside nursing while the professional nurse devotes her time to more intricate and delicate duties in the care of the sick.

Practical nurses work under the direction of a licensed physician or registered nurse in the care of mothers and new babies, convalescent, aged or chronically ill patients, tuberculous and chronic mental patients.

A person desiring to enter the practical nurses course must be a citizen of the United States, 18 years or over, of good moral character, physical and mental health, and have a 12th grade education or its equivalent.

The twelve-month course is divided into the regular school year of four quarters beginning Sept. 8, Nov. 15, Jan. 31 and Apr. 11, and followed by a summer term in June, July and August. Each student is permitted a three-week vacation period during the course.

Supervised Practice

In training, the practical nurses get lectures, demonstrations and supervised practice under qualified instructors. Each student gets from 5 to 10 weeks of actual practice in general nursing procedures, the care of convalescents, chronics and aged, children, mothers and infants, tuberculous and mental patients, and home care.

At the present time the course will cost a student about $80 for the school year. Non-residents, those who reside at the hospital while training, must pay one dollar per day for maintenance.

Training Periods

During the first training period of 9 or 10 weeks, the students will be expected to pay for their own room, board and laundry. In later training periods the students will be paid as follows:

Second and Third Training Period
$ 3.50 per week and full maintenance for non-residents.
$17.50 per week for Milwaukee residents living at home.

Fourth Training Period
$ 5.75 per week and full maintenance for non-residents
$19.50 per week for Milwaukee residents living at home

Fifth Training Period
$ 8.00 per week and full maintenance for non-residents
$22.00 per week for Milwaukee residents living at home.

Upon completion of the course each student will be granted a diploma and a cap by the Milwaukee Institute of Technology. Each girl thus graduated is eligible to take the licensing examination conducted by the State Board of Health, and if passed successfully, she will be issued a license of practice in Wisconsin as a licensed attendant, or trained practical nurse, in a hospital, private home, convalescent or nursing home, clinic or doctor's office.

Who Earns the Money? Survey Tells Answer

Washington, D. C., Sept. 1—The "middle income" of the 42,000,000 families in the United States was $2,920 last year, or an increase of $320 from 1946, the Federal Reserve Board has reported. It said that one-half of all incomes were higher than the middle figure, the other half lower.

Some 69%, or 28,980,000 families had joint incomes of $2,000 or more last year. In the mid-1930's fewer than 6,600,000 families had income of that level, but a dollar bought more.

PRACTICAL NURSES IN TRAINING AT MILWAUKEE VOCATIONAL SCHOOL — The course of study includes many hours of supervised practice in the care of mothers and infants, convalescents and the chronically ill.

FORUMETTE

AMA Approves Principle of Red Cross in Blood Program with Local Medical Societies

The threat of atomic warfare has recently caused medical societies to give greater consideration to the problem of immediate blood transfusion which would necessarily result from the explosion of atomic bombs among large centers of population.

This concern brought to light the fact that present facilities for collecting, storing and transporting blood are not enough to meet the demands of an emergency of such proportions. Few metropolitan areas could by themselves supply more than a fraction of the need for whole blood for their own use in such an emergency situation.

Ask Local Control

At the June 21–25 session of the AMA, the House of Delegates adopted a resolution dealing with the Red Cross Blood Bank system. Realizing the possibility of a national emergency requiring large amounts of blood in the treatment of civilian and military casualties and the unique position of the American Red Cross in disaster relief, the House expressed its opinion that no change should be made at this time in the approval in principle of the participation of the American Red Cross in the National Blood Program voted at the AMA Interim Session in January 1948. The House called attention, however, to the fact that long before the Red Cross entered the field many local blood banks operated independently and successfully, and expressed the opinion that it would be "unwise and disasterous" to disturb these local units. The major points which were "approved in principle" were these:

"First, Local control must be by the county medical society.

"Second, the local medical society should be the initial contact in the contemplation of inauguration of a new blood bank.

"Third, no publicity nor news releases shall be released except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

"Fourth, difference of opinion in establishment or operation of a blood bank in either administrative or technical detail shall be arbitrated at the state levels by joint committees from the state medical society and the American Red Cross."

The House recommended that the committee of the AMA be enlarged to nine members with instructions to meet at the call of either the chairman of the committee or that of the Red Cross. The House concluded its report on the Blood Banks with a statement that "any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it's the responsibility of an individual to assume the obligations of medical expenses just as he does for other living expense."

Superior Co-op Health Center Files for Incorporation Papers

Superior, Wis., Sept. 21—The Superior Cooperative Health Center has filed for incorporation papers, reports the Douglas County Register of Deeds. The incorporators announced their goal as a non-profit medical and dental hospital and clinic in Superior.

The incorporation papers indicate the new organization also contemplates establishment of a training school for graduate nurses, practical nurses and nurses.

Toivo A. Ekelin, one of the incorporators, said the group plans to hold a meeting in the near future to open a membership campaign with a goal of $200,000.

He explained that the organization was an outgrowth of the Co-operative Health association which has been in existence in Superior for 10 years and said this association would probably join with the new corporation.

Aside from plans to maintain a medical staff, the group plans to pay non-participating physicians and dentists set fees for their services. It also plans to buy and dispense drugs in the operation of the hospital.

Memberships will be issued without capital stock. An initial membership fee of $100 has been set up in the articles. Dues will be $2 a year, with $1 of this to go for research to the Co-operative Health Federation of America.

Private Physicians Averaged $9,884 Net Income During 1947

Rutherford, N. J., Sept. 2—The average net incomes of private physicians have almost tripled from a depression low in 1935 of $3,792 to a postwar high of $9,884 a year, according to *Medical Economics*, the national business magazine for physicians.

A survey made by the magazine showed that the gross incomes of private physicians averaged $17,476 for 1947. The net was after deduction for such professional expenses as office rental, personnel, utilities, automobile, instruments and medical supplies.

Young Doctors Have "Moral Obligation" for Army Service—AMA

Chicago, Sept. 15—The crisis in military medical personnel is still the subject of considerable controversy among military and medical circles.

Dr. James C. Sargent of Milwaukee, chairman of the AMA Council on Nationai Emergency Medical Service, has declared that the medical profession at all levels has the responsibility of urging the enrollment of young physicians, particularly V–12, ASTP, and others deferred in the last war in order to pursue their education.

"These men seem to have a moral obligation to serve, whether a new draft law is introduced to catch them or not", declared Doctor Sargent. An editorial in the Journal of the AMA on August 7 pointed out that 6,000 doctors will be needed in the early future "unless the rate of procurement of officers is rapidly and substantially increased and maintained the ability to provide medical care under the Selective Service Act is jeopardized", the AMA declared.

The Council of the Illinois State Medical Society made public a resolution adopted recently urging all young physicians to volunteer immediately for military service. The resolution is directed especially at those young doctors who received all or part of their medical education at the expense of the government, but who did not serve in the armed forces because the war ended before they completed their courses.

PUBLIC RELATIONS IN PRACTICE

The Indispensable You

Public relations is not just the art
of
Putting a message across;
Public relations is something
you're part of,
Either for profit or loss.
You, in your job, are the Society
emissary,
All that you say and you do
Counts—plus or minus—with Tom,
Dick and Harry,
Public relations is—you!

All that goes into winning the
people's
Confidence, friendship, good will,
You can knock higher than several
steeples
If you're a grouch and a pill.
You put the blessing, or you put
the curse on all
Planning and Policy too.
Public relations is private and per-
sonal,
Public relations is you!

It is by you that the citizen judges;
You give the public its slant;
You're the promoter of grins or of
grudges;
It's the impression you plant
That'll decide if your reputation's
Proved by performance, all
through.
Public relations is private rela-
tions;
Public relations is you!

(This poem was written by Berton Braley for "Service" the monthly publication of the Cities Service Company. Paraphrased slightly for the reader, it is reproduced here as something worthy of the attention of everyone in medicine.)

A cure for the C.D.T.'s . . . Dr. John A. Schindler, Monroe, recently addressed the Orangeville Woman's Club on the subject of the C.D.T's. "That", he said, "is the cause of 999 of the thousand different diseases which could fasten themselves upon mankind." The C.D.T's is Doctor Schindler's interpretation of psychoneurosis, meaning cares, difficulties and troubles.

PR–PR–PR–PR

DON'T MISS READING . . . "Doctor, My Statistics Feel Funny" in the Reader's Digest for August, 1948. "Will Compulsory Insurance Help Keep You Healthy?" in Better Homes and Gardens for September, 1948. "They're Trifling with your Life" in the July 24, 1948 issue of the Saturday Evening Post.

PR–PR–PR–PR

Well said, my friend . . . Monsignor Fulton J. Sheen has spoken very clearly on the subject of the method by which medical care should be provided: "When doctors oppose state medicine because they cannot make as much money as they do now, then state medicine is inevitable! When doctors oppose state medicine because they want to maintain a personal relationship with their patients, then the compulsory organization of human service is impossible!"

PR–PR–PR–PR

Preventive Medicine At Work . . . The medical societies of Trempealeau, Oconto and Rusk counties have launched county-wide immunization programs in cooperation with local health units. Designed to protect children against diphtheria, tetanus, whooping cough and smallpox, the program has added benefits, too. It serves to make the public aware of their responsibilities in making preventive medical care successful.

PR–PR–PR–PR

The Junior League of Racine is hoping to raise $17,000 for a Curative Workshop in the city to provide facilities for the physical rehabilitation of disabled accident or disease victims. The Racine County Medical Society is to provide an advisory board of six physicians to assume responsibility for all professional policies and problems.

PR–PR–PR–PR

A Pressing Need . . . Following a speech by Dr. H. H. Christofferson, Colby, to the Marshfield Rotary Club, the Marshfield *Journal* went to bat for the aged and chronically ill who have an "imperative need" for the proper type of infirmary care. It pointed out that little has come of previous efforts to build needed institutions, then commented: "Perhaps if advocates as able as Dr. Christofferson could be heard by everyone, the story would be a different one." Which all points to the fact that the citizens of Wisconsin urgently need the words of physicians to guide their actions in public health.

PR–PR–PR–PR

Repeat Performance . . . "There is a community job for Racine to do in planning a program for the care of the aged," the Racine Welfare Council was told recently by a panel of speakers, among them Dr. Randolph Kreul, president of the Racine County Medical Society. This is the type of leadership Wisconsin physicians can exercise in their communities. And it is the best type of public relations.

Illinois SMS Picks Three Farm Students for Medical Loans

Chicago, Sept. 24—Three men were welcomed to beginning medical careers with $5,000 loans to finance their studies, and the blessings of the Illinois Agricultural Association and the Illinois State Medical Society.

They are the first beneficiaries of the $100,000 joint medical student loan fund set up by the two organizations to finance the medical studies of men from rural communities who in turn agree to practice medicine in a rural Illinois community.

Under the plan men from rural communities who have premedical courses who are approved by local farm bureaus and medical societies and who agree to practice in rural communities are eligible for $5,000 loans at the rate of $1,000 a year to complete their four year medical courses and one year internships. All three candidates come from "priority counties" where the physician shortage is greater than other parts of Illinois.

Medicine Achieved Greatness in Free Enterprise—Bach

Chicago, Aug. 20.—No branch of science has made more progress during the last 50 years than the science of medicine, declared John L. Bach, AMA director of press relations, in a recent Kiwanis club address.

"Despite its shortcomings, its incompleteness, its groping, medicine, as it has grown under the American System of free enterprise, is today one of the great triumphs of the human spirit."

(Continued from page 1014)

cases of feeble-minded persons, two doctors must make the examination and advise the court. There are many other matters in which the county judge is compelled to seek the advice of a doctor. I find that in cases of juvenile delinquency in recent years it is almost necessary to have a psychiatric examination before passing on the case. We find boys sometimes go wrong because of some physical defect,—cross-eyes, defect in speech and so forth—and when these defects are corrected they become normal. I used to think that most difficulties of minors could be corrected with a good lecture, but I find that that is not enough. Often something else must be done. If there is any excuse for it, I send them first to a psychiatrist for an examination. Sometimes they find the trouble, but, whether they find it or not, we usually get results that fully compensate for the expense. If the children are impressed with the seriousness of their actions they are often reformed by this treatment alone. The treatment sometimes that gets the best result is to take the child away from his home and companions and place him on a distant farm under competent supervision for months or even years. In minor cases, I often order that the child be not permitted to leave the home premises unless accompanied by a parent between 7:00 p.m. and 7:00 a.m. for a period of several months. The results are usually good.

I consult doctors a number of times each week. In most of the matters I am able to allow a fee, but in many matters there is no fee provided and I find that the doctor never hesitates to give me the best advice he can, whether he is paid or not. As a result I try to see that the doctor gets adequate compensation for the cases that are paid for by the public and that they are paid promptly so that they have no collection difficulties with these cases.

Dr. W. D. Stovall in an article in *The Wisconsin Medical Journal* of May 1948, "The President's Page," gives the statistics and I will not repeat them. If you have not read this article, do so. It will be worth your while. The problem of the aged and infirm becomes more serious each year and the sooner we work to solve it, the easier it will be.—JAY H. GRIMM.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY CHANGES REQUIREMENTS AND REGULATIONS

A number of changes in the requirements and regulations of the American Board of Obstetrics and Gynecology were made at the annual meeting of the board, which was held in Washington, D. C., in May 1948. Foremost of the new regulations, which appear in a bulletin now available for distribution, are the following:

1. The ruling that applicants must receive adequate training in both obstetrics and gynecology has been defined as meaning a minimum of six months, full time, in the branch of either obstetrics or gynecology relegated to a minor role in a candidate's training and preference for practice.
2. Acceptable preceptorship training is defined.
3. The present regulation requiring at least six months of practice in the specialty following completion of an acceptable training period has now been extended, effective Dec. 31, 1949, to a requirement of two years' post-training practice limited to the specialty.
4. Specific requirements for approval of hospital services for residency training are outlined.
5. Effective immediately, there will be no further temporary approvals of hospital services for residency training. It is planned that all hospitals holding any type of residency training approval will soon be either resurveyed or initially surveyed by the Council on Medical Education and Hospitals of the American Medical Association so that all future approvals, new or old, will be based entirely upon inspection following application. It is expected also that certain resurveys will result in withdrawal of present residency approval from institutions where the educational and training standards are not being maintained.

The next scheduled examination (Part I), written examination, and review of case histories, for all candidates will be held in various cities of the United States and Canada on February 4, 1949. Applications may be made until November 1, 1948. Application forms and bulletins may be obtained from the American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

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Introducing Doctor Chisholm

A world citizen, a dynamic psychiatrist, a public health administrator, a general of the medical services of Canada in peace and war is Dr. G. Brock Chisholm.

As executive secretary of the Interim Commission of the World Health Organization, Geneva, Switzerland, he directs and guides the constitution of the United Nations in matters of health for an understanding of nations and their needs by remobilizing the medical sciences within the fields of social and mental health across international boundaries, with the ultimate goal to harmonize or to secure human relations, to insure enduring peace, and to save the human races' culture and civilization without distinction of race, religion, political belief, and social status. Doctor Chisholm stated in the W. A. White Memorial lectures (1945) human factors of world citizens, causes and actions which lead to total wars in an immature human society, that "man's freedom to observe, to think freely, and to act intelligently is as essential to his survival as are the specific methods of survival of the other species to them."

"Ghastly warfare, competitive survival has now become utterly obsolete as a method of staying alive, mass fighting has been one of the more constituent major patterns of behavior throughout the history of the human race without improving misunderstandings of peoples or explaining what is wrong with us," says Doctor Chisholm, warning "from now on man must live at peace with man or else die out as a species." Doctor Chisholm is hopeful that the psychiatrist is able to explain to people what is wrong and how the psychologic warping of feelings, emotions, and understandings can be erased without coloration of language and interpretation by the psychiatrists. International and national mental health training programs will, under competent leadership, make sane world citizens, "to help coming generations to be other than we have been."—H. H. REESE, M. D.

Health and Peace

THE echoes of the blast that wiped out Hiroshima and made the whole world tremble had not yet died down when the voices of scientists were first raised, saying: "We human beings must now stop fighting wars, or we shall destroy ourselves altogether!" These scientists have not ceased since then to state their case at every opportunity and in terms as emphatic as they could muster.

What they have been saying is far more true today than it was back in the summer of 1945. Just how much more true it is, is, of course, a closely guarded military secret. In any event it would seem that today's atom bomb, not to mention the far greater menace of the new bacteriologic weapons, makes the original model look altogether puny and relatively harmless.

But as this very real threat to man's survival increases, public concern over the prospect of our going the way of the dinosaur decreases. People are growing disinterested, apathetic—and, unfortunately, this seems to apply in particular to politicians and statesmen when, with a shrug of the shoulders, they incline to accept the probability of another war in the not-too-distant future.

Why is this?

Our species seems to have gone quite mad. Clearly, we are preparing to cut off our nose to spite our face. And not only our nose, but also our head! To express it a bit more technically: man's self-preservative instinct appears about to become the victim of a primitive sado-masochistic complex so powerful that racial suicide may be the result.

Undoubtedly there will not be complete agreement with this interpretation of mankind's headlong rush toward extinction. However, complete agreement is not necessary to recognize that highly significant mass psychologic factors must be involved in a situation where homo called sapiens stares sure death in the face with as little concern as he shows today.

What is being done about it?

Some few indications exist that steps may yet be taken in time to prevent the final catastrophe—steps based on a recognition of the mental hygiene aspects of the crisis we have reached. Not enough progress has been achieved along these lines so far to justify more than a fervent hope that we shall perhaps, after all, have a future. But a beginning at least has been made.

One significant indication that we have begun to see the connection between world peace and mental hygiene can be found in the constitution of the World Health Organization. This document, approved by fifty-four governments in every corner of the globe, contains these revolutionary concepts: first, that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"; and, second, that health thus defined is "fundamental to the attainment of peace and security."

Clinging to the mere acceptance of these concepts as ground for any hope might perhaps be dismissed as starry-eyed irrealism. But things have begun to move, though slowly still, toward the actual implementation of these concepts. The first World Health Assembly, meeting last summer in Geneva, recognized mental health as being clearly within the province of WHO's activities and instructed the organization's director-general to follow closely the recommendations of the International Congress on Mental Health and World Citizenship which was convened in London a few weeks later.

Thus it may be said that the first steps have been taken. Straws in the wind? They are, of course, little more than that so far; and only time will tell. Let us hope that we shall have enough of it!

Brock Chisholm, M. D.

Antivivisectionists Exposed*

The antivivisectionists love publicity pointed to their angle, but screams of anguish and tearing of hair will soon be reflected in the antivivisectionist publications after the recent article in the *Saturday Evening Post*, "They're Trifling with Your Life."

This article designates the antivivisectionists as "an obscure cult of sincere but misguided Americans —spurred by shrewd promoters—[which] now threatens to wipe out the techniques of medical research that have saved millions from horrible deaths."

There in the subtitle of the article is the core of the antivivisectionist issue as the medical profession has stated it again and again.

The vast majority of antivivisectionists are apparently sincere but misguided. They are kindly people who love animals perhaps too well. Their noble sentiments make them easy prey to the shrewd promoter who makes his living by claiming that animals in laboratories suffer needless pain, and that money is needed to stop animal experimentation. The people who support the antivivisectionist movement have never been in laboratories and have only the vaguest concept of what constitutes scientific research.

The combination of "sentimental money," as the gifts to antivivisectionism have been termed, plus shrewd promotion, embodies a real threat to medical research. The menace cannot be ignored as something remote rather than immediate. Year after year the antivivisectionists have had bills introduced into the Congress of the United States and into state legislatures "exempting" the dog from service in the medical research laboratory. Such bills, one of which came perilously near enactment in a New York legislature, serve as publicity springboards even when they fail of enactment. If the so-called dog bill should ever go through the Congress in a preadjournment legislative jam the event would be a catastrophe. Although these bills in the Congress apply only to the District of Columbia, they would serve, if passed, as patterns to be copied in state legislatures. In addition to attempting to effect state and national legislation, the antivivisectionists, by creating uproar and emotional tension, have succeeded in diverting many stray dogs which used to be delivered to medical schools to the gas chamber at the dog pound, thus increasing the difficulties experienced by medical schools in procuring dogs for study. Finally the antivivisectionists admit that the dog is used as their symbol because of mankind's universal love for dogs. If they once succeed in excluding dogs from use for medical research they will proceed to broaden this ban to include, first, cats, and gradually other animals.

The *Saturday Evening Post* has done an important and significant service to the health of the American people in exposing the threat of antivivisectionism. This is a courageous act, for the *Post* will inevitably be deluged with letters from the antivivisectionists. People who realize the importance of animal experimentation for medical progress should write to the *Saturday Evening Post* and commend the editors for their courage in submitting themselves to the annoyance and the threats sure to come from the antivivisectionists.

* Reprinted from the Journal of the American Medical Association, Sept. 11, 1948.

Introducing Doctor Fishbein

Since July 5 the world has watched Great Britain and wondered: Is the cradle to grave plan really working? How do the patients react? How does it affect the doctors? The AMA and most of its 136,000 members have wondered about the answers too.

To observe the effects of governmental medical care in the postwar world, Doctor Fishbein, AMA's author–scholar–authority, recently spent a month in Great Britain and continental Europe. In Britain he talked with general practitioners, hospital authorities, and governmental officials, seeking the facts about the early effects of Britain's newest venture into Socialism. He spent his mornings in the doctor's office, watching the paperwork interfere with the practice of good medicine. Without time for anything but a cursory examination, the doctor had to send his patients to the hospital—a procedure which pleased neither the patient nor the doctor. At the ministry of health he saw the forms and regulations which are "the heart, soul and digestive tract of a national health insurance system." In France, Germany, and the Scandinavian countries as well, he observed the bungling fingers of government regulation restrict freedom of the patient and the physician, destroy initiative, and create an administrative merry-go-round.

The readers of The Wisconsin Medical Journal are privileged to have here some of his latest thoughts on political medicine in America written in light of his observations during his travels throughout Britain and the Continent.—K. H. DOEGE, M. D.

Medicine as a World Problem

UNTIL fairly recent times, the care of the sick was never considered as a major political issue. Indeed it is doubtful that the people of most of the countries of the world apppreciated sufficiently the value of easily available good medical care to make it worth while for a political leader to put such service in the scale of offerings with which he hoped to attract the public's votes. When George Washington and Benjamin Franklin and other leaders talked about security, they were concerned with security from invasion by a foreign army or enemy. The concept of security beyond safety against pillage and plunder by foreign adversaries was not much in the public mind. As mankind has become softened, the word security has assumed a new meaning. Today security as used by political leaders means freedom from want, freedom from hunger and cold, freedom from illness, freedom from homelessness, freedom from the fear of disease, danger or death, freedom from dependency.

We acquire security against invasion by building suitable mechanisms of defense. An army, a navy and an air force of a strength sufficient to protect our borders on land, on sea and in the air is the greatest security that the nation can offer. When the concept of insurance became appreciated, men and nations began to protect themselves against certain hazards by putting aside in time of plenty against the needs of the future. Serious sickness is one of the most difficult hazards to meet because it strikes without warning. Modern scientific medicine has developed technics of diagnosis and treatment which are the surest protection against the hazards of illness. Most of the nations of the world have developed governmental systems of insurance against the costs of illness. The systems are compulsory because political leaders have been convinced that people could not be educated to protect themselves voluntarily. For almost half a century various political leaders in the United States have attempted to urge a compulsory sickness insurance system on the people of this country. Today the concept of compulsory sickness insurance is so thoroughly ingrained in such political beliefs as socialism and communism that it becomes impossible to consider compulsory sickness insurance apart from those political beliefs.

While the American medical profession has for the most part fought successfully against the incorporation of medical service into the government, the people of the United States with good medical leadership and with the support of statesmen who have not felt it desirable that medicine be a government function have established various systems of voluntary insurance against the costs of illness which have gained millions of supporters. The various schemes for insurance against the costs of hospitalization, surgical fees and even general medical care are now widespread throughout the nation and are gaining constantly in subscribers. We seem in the United States today well on the way toward developing a mechanism for insurance against the hazards of illness that may be as widespread and popular as our voluntary insurance against the hazard of death or of injury by motor car. At least 75,000,000 Americans now carry life insurance, and motor car insurance is almost universal.

The candidate of the Republican party has stated firmly his opposition to government systems of sickness insurance and has also stated his present belief that it should be possible in the United States to develop aid for those who cannot afford the costs of illness and medical care for those who cannot secure suitable medical care otherwise on local, county and state bases with perhaps some financial aid from the federal government and without attacking those fundamental liberties and responsibilities that are characteristic of the government of the United States. Revolutionary measures are not indicated by the condition of health of the people of the United States.

Since the United States has about as good a system for recording the spread of disease, the incidence of disease, its duration and the ability of a patient to recover as exists in any country in the world, the application of modern biostatistics enables us to determine where improvement should be attempted and the possibility of success in overcoming unwarranted losses. Because health has come into the area of political consideration, differences of opinion arise as to the significance of various statistics. Much depends on the conservatism or optimism of the person who is doing the estimating. Some will say that a certain incidence of cancer, of heart disease or of mental disease is inevitable and that improvement is to be accomplished only with the greatest of difficulty. Others will remark bluntly that we could overcome mental disease if we only had another 15 or 20 thousand psychiatrists and if we only had another million beds for mental patients. Some remark plausibly about the ability to prevent a vast amount of mental disturbance by teaching mental hygiene and attacking the causes of mental disorder. Mr. Ewing's report on "The Nation's Health" says that a million children now attending our public schools will spend some part of their lives as patients in mental hospitals and that the causal factors in this situation are to a great extent emotionally damaging experiences in infancy and childhood and in the circumstances surrounding children in their homes and in their community." A long range program and one with absolutely unlimited funds would have to be considered as a first step toward correcting the "emotionally damaging experiences of infancy and the circumstances surrounding children in their homes." Some nations have not hesitated to suggest that all children be removed from their homes and reared as wards of the state. However, many competent psychiatrists have insisted that the removal of children from suitable homes is one of the basic factors of disturbed mental health.

The people of the United States should determine now that they do not wish the public health to be a political issue. The report on "The Nation's Health" emphasizes that health is not a private concern of a few individuals or a few institutions. It is everybody's business. For that very reason the people of the United States should determine that they wish to approach their health problems scientifically under competent leadership and not delegate their health problems and their health control to persons without a competent knowledge of medicine or of the public health who consider the public health primarily an economic or political problem. Wherever health has become a principal government function, the quality of medical service is a secondary consideration. Yet physicians know that the quality of medical care is far more important than its quantity. There may be a feeling of security in the belief that a doctor, a health center or a hospital is immediately available to anyone who may wish to use them but doctors know that the competence of the personnel that delivers the medical service is the only true test of its efficiency.

I have just returned from a visit to most of the important countries of Europe where various systems of governmental medical care prevail. What I have seen has convinced me more than ever that the greatest benefit to the patient accrues when he goes to a competent doctor of his own choice and when the doctor feels that his responsibility is to his patient and that his ability to advance in medicine as a career rests on the extent to which he succeeds with his patient. This is the system of mutual responsibility between doctor and patient that prevails for the most part in the United States and it is, moreover, the application of the doctrine of free enterprise to medical care.

Morris Fishbein, M. D.

Minutes of the Council Meeting, Hudson, May 15 and 16, 1948

1. Call to Order

The Council was called to order by Chairman Gavin at 8:00 p. m., Saturday, May 15, 1948, at the City Hall, Hudson.

2. Roll Call

Councilors present were Doctors Hemmingsen, Vingom, Dessloch, Heidner, Gavin, Fox, Bell, Christofferson, Arveson, Ekblad, Fitzgerald, Truitt, and Past-President Dawson.

Also present were President Stovall; President-Elect Doege; Speaker of the House of Delegates Gundersen; Dr. J. S. Supernaw, chairman of the Operating Committee of the Wisconsin Veterans Medical Service Agency; Dr. L. R. Cole, University of Wisconsin, Madison; Mr. T. J. Doran, director of the Veterans Agency; Mr. Ralph F. Weber, director of Wisconsin Physicians Service; Secretary Crownhart; Assistant Secretary Ragatz; Mr. Earl Thayer, public relations; and the Misses Margaret Kracht and Helen L. Brandt of the Society's office.

Members of the Pierce–St. Croix County Medical Society were invited as guests at the Saturday evening meeting.

3. Communications

The secretary reviewed communications received from recipients of the Fifty Year Club lapel button and Life Membership in the Society, expressing appreciation for tributes paid them.

4. Interim Report of the Secretary

The secretary reported the death of Mrs. Mary Davis, staff member who had joined the Society's office four years ago. Her work consisted of the development of the radio program, "The March of Medicine," and she gave splendidly of her effort, time, and energy to the work of the profession.

On motion of Doctors Arveson–Hemmingsen, Doctor Stovall was asked to write an appropriate letter to Mrs. Davis' relatives, expressing the sympathy of the Council. On motion of Doctors Ekblad–Fitzgerald, an amendment to the motion provided that a copy of that memorial be sent to each radio station which participated in the "March of Medicine" program. Doctor Arveson asked that the amendment be incorporated in his motion, and the Council gave a rising vote to indicate its unanimous approval.

The secretary reported that his office staff members had attended more than eighty-six meetings in official activities of the State Medical Society or national meetings of the American Medical Association and other organizations. He then presented problems confronted by Blue Cross and Blue Shield plans in national enrollment.

There was general discussion with regard to the proposed merger of Blue Cross and Blue Shield and the meeting of the National Health Assembly at Washington, following which, on motion of Doctors Dessloch–Ekblad, carried, the Council affirmed the position taken by its representatives at meetings of the Blue Cross–Blue Shield movement and the National Health Assembly and urged them to continue their efforts in the same direction.

5. Meeting on Blue Cross–Blue Shield Plans

The secretary reported that a communication had been received from the American Medical Association asking for the designation of a physician or representative to attend a meeting on June 19 with regard to the merger of Blue Cross and Blue Shield plans.

It was moved by Doctors Ekblad–Dessloch, carried, that the president of the Society either attend the meeting or appoint a representative to do so.

6. Interim Report of Wisconsin Physicians Service

Doctor Vingom, chairman of the Directing Board of Wisconsin Physicians Service, and Mr. Ralph Weber, executive director, reported on the current status of this plan.

It was stated that $9,269.84 was added to reserves for maternity benefits, disaster claims, and unforeseen contingencies, during the first quarter of 1948. Total reserves of $30,228.12 were reported for the year of operation, 1947, up to March 31, 1948. Persons covered totaled 55,691 as of March 31.

On motion of Doctors Dessloch–Ekblad, carried, the Council commended Mr. Weber and his staff for the work they are doing in the development and promotion of Wisconsin Physicians Service. There was discussion of the structure and responsibilities of Wisconsin Physicians Service.

It was moved by Doctors Ekblad–Dessloch that the Directing Board of Wisconsin Physicians Service make any recommendation it saw fit to the Council, with an amendment proposed by Doctor Truitt, and accepted, asking Wisconsin Physicians Service to first submit recommendations to the Interim Committee for screening. As amended, the motion was carried.

7. National Health Assembly

Doctor Gundersen, Doctor Cole, Doctor Truitt, and Mr. Crownhart reported on a meeting of the National Health Assembly held in Washington May 1–4, 1948.

8. Committee Appointments

Appointments of the chairman of the Council to Council committees were announced at this time, and appear on page 617 of the June 1948 *Wisconsin Medical Journal.*

9. Report of the Veterans Medical Service Agency

Doctor Supernaw, chairman of the Operating Committee of the Veterans Medical Service Agency, and Mr. Thomas J. Doran, director, reported on the progress of the Agency to date. It was stated that a total of $703,000 was received from the Veterans Administration in authorizations, and the total value of claims filed with the V. A. was $544,000. Total cash received was $521,000, and paid to doctors, $475,000. The Agency returned to the V. A. a total of $137,000 in authorizations that were either cancelled entirely, or partially used.

Mr. Doran stated that the Agency handled the $137,000 worth of authorizations without compensation, but that attempts were being made to obtain 10 per cent of this figure for the cost of handling the authorizations.

He further stated that the osteopaths would like to have the same type of service through the Agency as the members of the Society are obtaining. In addition, there are authorizations approximating $10,000 issued by the V. A. for outpatient medical care outside the Agency, including such organizations as the Curative Workshop in Milwaukee, the Curative Workshop in Oshkosh, and physiotherapy departments. These organizations would also like to become a part of the service offered by the Agency.

After discussion, it was moved by Doctors Truitt–Christofferson, carried, that the osteopaths be included in the Veterans Agency program, under the limitations of their state license to do so, and that the Agency be given power to work out the details of that arrangement.

It was further moved by Doctors Fitzgerald–Dessloch, carried, that the curative workshops be included within the services of the Agency.

10. Interim Committee Report

Doctor Stovall, president, reported that the Interim Committee had reviewed such matters as the Associated Medical Care Plans, Blue Cross, the American Medical Association, and the Society's relation to them in carrying out various operations; cooperative health plans, enrollment of physicians in the Wisconsin Plan and Wisconsin Physicians Service; procedures of Wisconsin Physicians Service; scientific activities of the Society; the membership department; and other miscellaneous matters.

11. Ex-Officio Members of Interim Committee

Doctor Stovall reported that the Interim Committee suggested to the Council that the assistance of certain officers of the Society was deemed advisable to the Interim Committee. It was therefore recommended that the chairman of the Council and the president-elect be made ex-officio members of the committee without the right to vote.

On motion of Doctors Hemmingsen–Dessloch, carried, this recommendation was approved.

12. State Society Office Building, Management, Finances

The secretary reported that the Interim Committee had considered the whole problem of managing and financing the new headquarters building of the State Society, and had recommended that the Council formally establish a separate building account for the receipt of income and payment of expenses incurred in the operation of the building. Secondly, it recommended that a committee be charged with the management of the building under the general direction of the Council.

Following discussion, it was moved by Doctors Dessloch–Arveson, carried, that a separate bank account at the First National Bank in the city of Madison be established for the operation of the building, to be known as the Building Fund Account, and that the officers of the Society—the treasurer and the secretary, or the assistant secretary, be authorized to draw upon that account when properly vouchered.

It was also moved by Doctors Ekblad–Arveson, carried, that the members of the Interim Committee be charged with general supervision and operation of the building, together with Doctors Vingom and Sisk, treasurer.

13. County Constitutions and By-Laws

The secretary reported that the House of Delegates in October 1947 authorized the state office to ask each county medical society for a copy of its constitution and by-laws to be kept on file within the office, together with any amendments or changes or rules of each society.

The Interim Committee had suggested that the Council authorize the appointment of a special committee to review any problems that may arise in the various counties.

It was moved by Doctors Christofferson–Ekblad, carried, that the chairman appoint a committee of three to review all of the county society constitutions and by-laws and make recommendations to those counties where by-laws are inconsistent with those of the State Society.

14. Study of Fee Schedules

A recommendation of the Interim Committee was reviewed providing that the Council grant it the privilege of studying all fee schedules and relationships with state and federal agencies in an effort to finally determine upon a uniform schedule on a unit basis. The Interim Committee stated that it would then make recommendations to the Council and to various bodies with reference to any special contract with an individual state or federal department.

It was moved by Doctors Ekblad–Fitzgerald, carried, that the Interim Committee be given the privilege of studying fee schedules as suggested.

15. Centennial Exhibit Authorized

The secretary and assistant secretary reported that the Centennial Committee had tried to obtain suitable space at an appropriate charge for a health exhibit at the State Centennial in Milwaukee. However, such accommodations were not available at a sum which could be obtained from the Society and other interested agencies. Therefore, the Centennial

Committee suggested that the project be discontinued.

This matter was discussed at the meeting of the Interim Committee held on August 14, and it was that committee's recommendation that further attempts be made to obtain these facilities, and that the Council authorize a further appropriation of $1,000 for this purpose.

It was moved by Doctors Fitzgerald–Bell, carried, that this recommendation be accepted.

16. Committee on Communicable Diseases

A request of the State Board of Health, submitted to the Council by the Interim Committee, asked for the appointment of a committee of the State Society to study proposed changes in communicable disease regulations and to make recommendations.

On motion of Doctors Dessloch–Hemmingsen, carried, the appointment of such a committee was authorized.

17. National Emergency Medical Service

Mr. Thayer reported on a meeting of the Council on National Emergency Medical Service with representatives from state medical societies, the allied medical profession, and the Army, Navy, and Air Force. This meeting was held in Chicago on May 5 and 6 for the purpose of discussing the provision of medical, health, and sanitary services for the civilian population in industry, agriculture, and the armed forces in times of a national emergency.

Discussion was given to how medical societies might take an active part in forming a civilian defense system and in coordinating and regulating the induction of, or cooperation of, physicians in another emergency.

On motion of Doctors Heidner–Dessloch, carried, a recommendation of Doctor Sargent was accepted to refer the problem to the Society's Committee on Military Medical Service with the request that it make a detailed study and keep the Council informed.

18. Anesthesiologists' Request for Representation

A request of the Wisconsin Society of Anesthesiologists was considered in which representation on the Wisconsin Plan Committee was asked.

Following discussion, it was moved by Doctors Dessloch–Arveson, carried, that the directing committee of the Wisconsin Plan act on this request as it wished.

19. W.I.A.A. Program Authorized For One-Year

At the last meeting of the Council, the proposal of a subcommittee of the Council on Medical Service and Public Relations to cooperate in a program to provide benefits to members of the Wisconsin Interscholastic Athletic Association, was re-referred to the Council on Medical Service and Public Relations for further study. That Council considered the program at some length and recommended that the general Council approve its recommendations for a trial period of one year.

Doctor Supernaw pointed out that the program does not offer full coverage and that the statement to be included in notices to parents would explain that "the benefit provided may be supplemented by additional charges by the physician caring for the patient."

It was moved by Doctors Heidner–Bell, carried, that the recommendations of the subcommittee of the Council on Medical Service and Public Relations be followed for a trial period of one year.

An amendment to the motion was offered by Doctors Ekblad–Dessloch to provide that the recommendations be submitted to each county society so that it may decide whether it wished to participate. This motion was not carried.

20. Mid-Winter Scientific Programs

A suggestion from the Council on Scientific Work was discussed which proposed the possibility of developing mid-winter programs in which Wisconsin physicians would serve as speakers. It was felt that the annual program does not give physicians of Wisconsin an ample opportunity to participate in medical meetings and that the Council on Scientific Work could well stimulate such participation by having a meeting developed and devoted to in-state speakers, similar to that in Michigan. One purpose that might be accomplished by such a mid-winter conference would be the stimulation of the section on general practice.

Following discussion, it was moved by Doctors Christofferson–Dessloch, carried, that the recommendations of the Council on Scientific Work to establish a mid-winter scientific conference be laid on the table.

21. Sections of the State Medical Society

Two sections of scientific medicine had requested the Council to approve them as authorized sections of the Society. The formal request of the Section on Pediatrics and the informal request of the Section on Anesthesiology were reviewed.

On motion of Doctors Dessloch–Ekblad, carried, the Council referred the matter to the House of Delegates for action.

22. Membership of Dr. G. W. Krahn, Oconto County, Accepted

The secretary reported that Doctor Bell, councilor of the Eighth District, had informed him that the Oconto County Medical Society had accepted Dr. G. W. Krahn into full membership in that society. Doctor Krahn is temporarily practicing in Florida although his legal residence is maintained in Oconto Falls, Wisconsin.

23. Invitation to Prairie du Chien

Doctor Dessloch, on behalf of the Crawford County Medical Society and the Dr. William Beaumount Foundation and the Fourth Councilor District, extended an invitation to the Council to meet in Prairie du Chien as soon as convenient. A Council meeting was held in Prairie du Chien May 1945.

24. Life Membership

On motion of Doctors Heidner–variously seconded, life memberships were granted to Drs. Thomas E. Malloy, Random Lake; John A. Junck, Sheboygan; and Conrad T. Tasche, Sheboygan.

On motion of Doctors Hemmingsen–Fitzgerald, carried, life memberships were granted to Drs. Henry J. Brehm, Racine; Louis E. Fazen, Racine; A. L. Nelson, Racine; C. R. Treat, Sharon; F. W. Pope, Racine; and F. A. Malone, Waterford.

On motion of Doctors Arveson, variously seconded, life memberships were granted to Drs. Victor F. Marshall, Appleton; C. G. Maes, Kimberly; J. H. Doyle, Little Chute; E. H. Brooks, Appleton; and C. D. Boyd, Kaukauna.

On motion of Doctors Truitt–Fitzgerald, carried, life membership was granted to Dr. A. W. Gray, Milwaukee.

25. Publication of Political Addresses

Doctor Doege presented a request from a member of the Society that the speech made by Governor Dewey before the House of Delegates of the Oregon State Medical Society be published in *The Wisconsin Medical Journal.*

Following discussion, it was moved by Doctors Christofferson–Dessloch, carried, that the matter be laid on the table until after the Republican convention.

26. Thanks Expressed to Doctor Newton and Doctor Dawson

On motion of Doctors Dessloch–Heidner, carried, the Council expressed its thanks to Dr. J. E. Newton, mayor of Hudson, for the facilities he provided for the Council meeting.

Doctor Truitt amended the motion to include Doctor Dawson, and the Council expressed its approval and appreciation to him for his assistance.

27. Adjournment

The meeting adjourned at 1:30 p. m.

C. H. CROWNHART
Secretary

EXECUTIVE SESSION

The Council met in a short executive session immediately following the 1:30 adjournment. At that time, it was moved, seconded, and the motion carried, that the secretary, Mr. C. H. Crownhart, be given an increase in his base salary to be paid in December 1948, so that at the end of the calendar year, 1948, his total salary, including the cost of living bonus, will equal $12,500.

C. O. VINGOM, M. D.
Secretary of the Executive Session

Approved:
S. E. GAVIN, M. D.
Chairman of the Council

RECENT WISCONSIN LICENTIATES

At a meeting held in Milwaukee on June 29 and 30 and July 1, the Wisconsin State Board of Medical Examiners licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Address*
Albrecht, J. E.	Wisconsin	1947	170 West Saveland, Milwaukee
Anderson, R. R.	Wisconsin	1947	702 South Prospect, Madison
Averbook, B. D.	Wisconsin	1945	1621 John Avenue, Superior
*Baldi, J. B.	Northwestern	1948	6100 North Park Road, Milwaukee 9
Baum, G. L.	Wisconsin	1947	715 North Eleventh Street, Milwaukee
Becker, I. M.	Wisconsin	1947	3045 North Maryland, Milwaukee
Benson, J. E.	Wisconsin	1947	626 Cass Street, La Crosse
Bittle, K. A.	Marquette	1947	3278 North Forty-Ninth Street, Milwaukee 10
Bland, P. T.	Wisconsin	1947	3009 Jerome Street, Madison
Bleck, E. E.	Marquette	1947	St. Francis Hospital, Chicago
Boren, J. A.	Northwestern	1948	617 South Raymond, Marinette
Brodhead, R. H.	Wisconsin	1945	Wisconsin General Hospital, Madison
Brown, J. G.	Wisconsin	1947	Mineral Point
Cofrin, D. A.	Cornell	1947	Milwaukee Hospital, Milwaukee
Cook, F. D.	Wisconsin	1947	535 West Central, Chippewa Falls
Cornwall, M. A.	Marquette	1946	979 Beech Street, St. Paul, Minnesota
Couch, J. R.	Marquette	1947	1633 South Eightieth Street, West Allis
*Curtis, W. C.	Marquette	1947	Milwaukee County Hospital, Milwaukee
Dedinsky, G. A.	Marquette	1947	5000 West Chambers, Milwaukee
Demke, R. L.	Loyola	1947	1425 North Linder, Chicago
Dockery J. N.	Marquette	1945	640 Hawthorne, South Milwaukee
Dorn, R. V.	Marquette	1946	2320 North Lake Drive, Milwaukee 11
Duffy, H. R.	St. Louis	1947	2107 North Hackett, Milwaukee
Dean, A. E.	Wisconsin	1947	Augusta
Ferris, Shirley L. (F)	Albany	1947	1458 New Scotland Rd., Slingerlands, N. Y.
Flaherty, N. F.	Illinois	1946	1211 Edmer Avenue, Oak Park, Illinois
Flaherty, R. A.	Marquette	1947	1211 Edmer Avenue, Oak Park, Illinois

Name	School of Graduation	Year	Address
Gage, R. S.	Marquette	1947	420 West Fifth Street, Appleton
Gerth, R. E.	Marquette	1947	117 Liberty Street, Oshkosh
Giller, Herbert	Wisconsin	1947	1110 Seminole, Madison
Glasson, L. G.	Marquette	1947	3321 North Maryland, Milwaukee 11
Gocke, T. M.	Wisconsin	1947	129 East Wisconsin Avenue, Neenah
*Grade, J. O.	Marquette	1947	2123 North Thirty-Second Street, Milwaukee
Gray, R. S.	Marquette	1947	213 Liberty West, Evansville
Guju, J. G.	Marquette	1947	712 Bennington, Youngstown, Ohio
Gulyash, J. J. F.	Illinois	1944	1509 Carlisle, Racine
Gunn, J. A.	Wisconsin	1947	501 St. Joseph, Marshfield
Guthrie, J. M., Jr.	Louisville	1946	315 North Scott Street, South Bend, Indiana
Hartenstein, Hans	Wisconsin	1947	830 East Mason, Milwaukee
Haug, T. M.	Wisconsin	1947	Route 14, Box 362, Milwaukee 14
Haugh, J. J.	Marquette	1947	2520 North Frederic, Milwaukee
Heise, L. F.	Marquette	1947	185 Hazel Street, Oshkosh
Henderson, J. A.	Wisconsin	1947	Ancker Hospital, St. Paul, Minnesota
Hill, E. F.	Wisconsin	1947	125 West College Avenue, St. Paul, Minnesota
Hoffman, W. K.	Marquette	1947	5522 West Washington Avenue, Milwaukee 8
Hoffmann, W. C. P.	Marquette	1947	1737 Church Street, Wauwatosa
Howell, D. A.	Wisconsin	1947	305 Second Avenue East, Fennimore
Iwen, G. W.	Wisconsin	1947	Wabeno
Jeffries, D. A.	Wisconsin	1947	601 West Eagle, Shawano
Junkerman, C. L.	Marquette	1947	2637 North Cramer, Milwaukee 11
Kanin, H. J.	Marquette	1947	3910 North Sherman, Milwaukee
Kann, Solomon	Wisconsin	1947	690 East Ninety-Ninth Street, Cleveland, Ohio
Karnopp, Irma M. (F)	Marquette	1947	89 Genesee Street, Rochester, New York
Kascht, R. L.	Northwestern	1948	2200 West Kilbourn, Milwaukee
Kelble, J. A.	Marquette	1947	1228A North Nineteenth Street, Milwaukee
Kersting, D. W.	Marquette	1947	Milwaukee County Hospital, Wauwatosa
*Klobucar, J. J.	Marquette	1947	St. Mary's Hospital, Duluth, Minnesota
Koepsell, J. E.	Wisconsin	1947	546 North Fifteenth Street, Milwaukee
Kohn, A. M.	Marquette	1947	4888 North Twenty-First Street, Milwaukee
Kuehn, Eleanor V. (F)	Wisconsin	1947	1654A South Thirty-Fifth, Milwaukee
Kulick, George	Marquette	1947	166 Coal Street, Nesquehoning, Pennsylvania
Kulick, Michael	Marquette	1947	166 Coal Street, Nesquehoning, Pennsylvania
Larkey, J. A.	Marquette	1946	3818 North Frederick, Milwaukee
LeTellier, G. B.	Temple	1947	1292 North Sixty-Third Street, Wauwatosa
Lovshin, W. C.	Wisconsin	1947	More Clinic, Eveleth, Minnesota
*McCreary, W. K.	Northwestern	1948	529 North Sixtieth Street, Milwaukee
*McEnroe, J. E.	Albany	1947	Grace Hospital, Detroit, Michigan
McIntosh, J. F.	Wisconsin	1947	6 Hillside Terrace, Madison
McLeod, J. J., Jr.	Marquette	1947	Birchwood
Mahre, J. A.	Wisconsin	1947	City Hospital, St. Louis, Missouri
Masley, A. L., Jr.	Wisconsin	1947	3626 Spring Trail, Madison
Means, J. A.	Marquette	1947	3254A North Thirty-Third St., Milwaukee 10
Meighan, P. P.	Marquette	1946	1120 Glenview, Wauwatosa
Meyer, W. W.	Chicago	1947	130 South Third, Medford
*Mickle, K. C.	Wisconsin	1947	3321 North Maryland, Milwaukee
Mikolajczak, N. A.	Marquette	1945	2000 North Fifty-Ninth Street, Milwaukee
Mitz, Morris	Wisconsin	1947	3051 North Forty-Fifth Street, Milwaukee
Moen, P. W.	Wisconsin	1947	East Ellsworth
*Moldenhauer, Ruth M. (F)	Wisconsin	1947	435 North Randall, Madison
Olinger, J. K.	Marquette	1946	813 Lincoln Avenue, Waukesha
O'Malley, R. J.	Northwestern	1948	4766 North Idlewild, Milwaukee 11
O'Toole, J. J.	Marquette	1947	4804 North Newhall, Milwaukee
Patow, W. E.	Marquette	1947	369 Glendale, Highland Park, Michigan
Pavelsek, J. W.	Wisconsin	1945	1028 East Avenue, Holdrege, Nebraska
Piehl, Marjorie R. (F)	Wisconsin	1947	Seymour
Podruch, P. E.	Marquette	1947	325 Sturgeon Road, Wausau
Ratke, Donald	Marquette	1947	2661 North Fifty-Sixth Street, Milwaukee 10
Rau, Esther L. (F)	Loyola	1946	215 Forest Park, Janesville
Rotter, Royal	Wisconsin	1947	2843 North Sherman, Milwaukee
Roubik, J. J.	Marquette	1947	1606 South Thirty-Third, Milwaukee
Saichek, R. P.	Marquette	1946	2803 North Fifty-Second Street, Milwaukee
Samuelson, Clarence	Marquette	1946	5000 West Chambers, Milwaukee 10
Santilli, M. A.	Marquette	1947	302 South Tenth Street, La Crosse
*Schlenker, L. T.	Marquette	1947	St. Francis Hospital, Evanston, Illinois
Smirl, W. G.	Columbia	1945	147 Wilbur Avenue, Waukesha
Smith, D. R.	Chicago	1947	950 East Fifty-Ninth Street, Chicago 37

Name	School of Graduation	Year	Address
Solomon, Seymour	Marquette	1947	3002 North Forty-Fifth Street, Milwaukee 10
Stehlin, J. S.	Marquette	1947	Milwaukee Hospital, Milwaukee
*Stephens, W. E.	Wisconsin	1947	335 Woodland, Oconomowoc
*Stiehl, C. W.	Northwestern	1948	Columbia Hospital, Milwaukee
Stollenwerk, K. J.	Marquette	1947	5643 South Nicholson, Cudahy
Sutherland, D. H.	Marquette	1946	2321 East Michigan, Evansville, Indiana
Sweeney, J. D.	Marquette	1947	4315 West Lisbon Avenue, Milwaukee
Tacke, A. W.	Marquette	1946	615 West Melvina, Milwaukee 12
Tempereau, C. E.	Wisconsin	1947	11311 Shaker Boulevard, Cleveland, Ohio
Thurwachter, L. F., Jr.	Wisconsin	1945	1239 E. Broadway, Waukesha
Waisman, H. A.	Wisconsin	1947	1819 West Polk Street, Chicago
Wallner, E. F.	Marquette	1946	2367 North Sixtieth Street, Milwaukee
Walton, Judith D. (F)	Wisconsin	1947	2122 Vilas Avenue, Madison
Watzke, D. F.	Wisconsin	1947	130 Lathrop, Madison
Wegner, C. J.	Wisconsin	1945	2640 Chamberlain, Madison
Whipple, A. A.	Wisconsin	1947	8537 Watertown Road, Milwaukee
Wippermann, E. D.	Wisconsin	1947	320 Ludington, Columbia
Wolf, Lawrence	Marquette	1946	Jewish Hospital, St. Louis, Missouri
Zupanc, Edward	Wisconsin	1947	Wisconsin General Hospital, Madison

The following physicians were licensed at Cable, Wisconsin on August 27:

*Coletti, A. E.	Louisville	1933	Mendota State Hospital, Madison
Hinke, D. H.	Pennsylvania	1944	118 South Mills Street, Richland Center

* Application incomplete.

At a meeting held in Milwaukee on June 29–30, July 1, the Wisconsin State Board of Medical Examiners granted licenses through reciprocity to the following physicians.

Name	School of Graduation	Year	Address
Barry, G. R.	Chicago	1942	1454 University Terrace, Ann Arbor, Michigan
Baumeister, Max, Jr.	Virginia	1945	109 North Seventh Street, Madison
Brown, A. W.	Virginia	1930	Algoma
Brown, D. J.	Illinois	1935	750 South State Street, Elgin, Illinois
Byrn, R. W.	Michigan	1940	614 Forest, Ann Arbor, Michigan
Ciccantelli, M. J.	Pennsylvania	1945	East Troy
Clanton, E. L.	St. Louis	1940	Milwaukee County General Hospital, Milwaukee
Clark, W. S., Jr.	Pittsburgh	1938	239 Rockland Street, Calumet, Michigan
Davies, J. A., Jr.	Marquette	1945	3602 North Sixteenth Street, Milwaukee
Dodge, R. K.	Cincinnati	1944	826 North Cass Street, Milwaukee
Fant, J. R.	Indiana	1940	411 East Mason Street, Milwaukee
Fleming, N. E.	Louisville	1945	114 Grand Avenue, Wausau
Gettelman, S. T.	Illinois	1944	State Sanatorium, Mt. Vernon, Missouri
Gowan, L. R.	Minnesota	1923	2320 East Third Street, Duluth, Minnesota
Grotts, B. F.	Chicago	1944	Milwaukee Children's Hospital, Milwaukee
Hank, G. C.	Wisconsin	1942	465 Sidney Street, Madison
Hannon, T. R.	Harvard	1926	2625 San Jacinto Street, Houston, Texas
Hayworth, Ballard	Iowa	1944	Wisconsin General Hospital, Madison
Jones, W. S.	Marquette	1943	University Hospital, Iowa City, Iowa
Kohler, S. H.	Marquette	1945	2760 North Fiftieth Street, Milwaukee
Kolman, I. E.	Georgia	1938	Madison General Hospital, Madison
Kukral, A. J.	Illinois	1944	1928 South Fifty-seventh Street, Cicero, Illinois
Larrabee, W. F., Jr.	Minnesota	1940	Schiek Clinic, Rhinelander
Lutz, E. A.	Rush	1929	1401 South Hope Street, Los Angeles, Calif.
Lillie, J. C.	Michigan	1939	1509 Damon Court, Rochester, Minnesota
MacGregor, J. K.	Columbia	1944	4002 Hammersley Avenue, Madison
O'Connor, W. B.	St. Louis	1942	Marshfield Clinic, Marshfield
Ohrenstein, I. R.	Illinois	1941	3533 Grenshaw Street, Chicago
Padorr, M. P.	Illinois	1941	913 Main Street, Racine
Powell, R. A.	Marquette	1943	11359 Roxbury, Detroit, Michigan
*Rapp, R. T.	Illinois	1944	Williamson, West Virginia
Sahs, M. H.	Iowa	1944	Spooner
Sheridan, F. M.	Pennsylvania	1945	Winter
Shonyo, E. S.	Rush	1937	Mayo Clinic, Rochester, Minnesota
Sukis, A. E.	Illinois	1936	3534 West 111th Street, Chicago
Taylor, S. F.	Chicago	1945	116 East Pleasant Street, Portage
Theiler, A. C.	Marquette	1945	New Holstein
Wiley R H.	Marquette	1945	Stoughton
Wilson, Hugh	Northwestern	1942	Route 1, Mundelein, Illinois
Wyland, J. S.	Georgetown	1933	1857 North Seventy-second Street, Milwaukee

* Application incomplete.

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Society Proceedings

Brown—Kewaunee—Door

Golf, cruising on the bay, and sailing were activities enjoyed by members of the Brown–Kewaunee–Door County Medical Society when they met at Leathem Smith Lodge at Sturgeon Bay on September 16. Following dinner, a paper on "Nutritional Therapy" was presented by *Dr. Donald Willson*, a member of the staff of Columbia Hospital in Milwaukee.

Outagamie

Meeting at the Conway Hotel in Appleton on September 16, members of the Outagamie County Medical Society heard a talk by *Dr. M. C. F. Lindert* of Milwaukee. The title of his paper was "Differential Diagnosis of Jaundice and its Clinical Application." Following the scientific program, there was a discussion of the resolutions to be presented to the House of Delegates of the State Medical Society.

Polk

Members of the Polk County Medical Society were guests of *Dr. V. C. Kremser* at Forest Wood Lodge in Amery on August 19. Dr. Leo A. Nash of St. Paul was the guest speaker, discussing the "X-Ray Diagnosis of Chest Diseases."

Vernon

Two members of the American College of Chest Physicians addressed the meeting of the Vernon County Medical Society on August 27 at the Westby Cafe in Westby. *Dr. L. H. Hirsh* of Milwaukee spoke on the "Modern Treatment of Chest Disease," and *Dr. A. L. Banyai*, also of Milwaukee, discussed the "Modern Treatment of Cough." A short business meeting was also held.

Washington—Ozaukee

J. F. KUZMA

Dr. Joseph F. Kuzma, Milwaukee pathologist, was the guest speaker at the August meeting of the Washington–Ozaukee County Medical Society, which was held at the Republican Hotel in Kewaskum on August 26. He presented a paper entitled "Diseases of the Breast." Members of the Auxiliary were guests at a dinner preceding the scientific program, and held a separate meeting following the dinner.

Richland

Meeting at Richland Hospital in Richland Center on September 28, members of the Richland County Medical Society heard a talk by Mr. Harry Carswell of Richland Center. Doctor Carswell, who is superintendent of Richland Hospital, discussed "Hospital Problems."

Central Wisconsin Society of Ophthalmology and Otolaryngology

The Central Wisconsin Society of Ophthalmology and Otolaryngology held its semiannual meeting at the Pember Eye, Ear, Nose and Throat Clinic in Janesville on September 11 and 12. Guest speakers at the conference were Dr. Orville Gordon, instructor in the department of ophthalmology at Northwestern University Medical School; Dr. E. O. Van Alyea, associate professor of otolaryngology at the University of Illinois College of Medicine; and Austin Belgard, Paul Gougelman, and Fay Freeman, all of Chicago.

Wisconsin Surgical Society

The semiannual meeting of the Wisconsin Surgical Society was held in Madison, September 18. The morning was given over to surgical clinics directed at the Methodist Hospital and the Wisconsin General Hospital.

There was a scientific meeting in the afternoon. The president of the Society, *Dr. E. R. Schmidt*, presided over a series of papers presented by members of the Society. These papers were as follows:

"Experiences with Vagotomy in the Management of Gastroduodenal Ulcer"—*Dr. Sherrill Rife*, Milwaukee.

"Synergistic Gangrene and Burrowing Ulcers"—*Dr. Russell M. Kurten*, Racine.

"Treatment of Alkalosis with Ammonium Chloride"—*Dr. James M. Sullivan*, Milwaukee.

"Enterogenous Cyst of the Ileum; a Case Report"—*Dr. G. N. Gillett*, Racine.

"Some Problems in Dealing with Carcinoma of the Rectum and Sigmoid Colon"—*Dr. Joseph J. Gramling, Jr.*, Milwaukee.

"Skin Implants in the Repair of Large Recurrent Hernias"—*Dr. G. S. Flaherty*, South Milwaukee.

At the dinner meeting in the evening, the guest speaker for the day, *Dr. Ovid O. Meyer*, professor of medicine at the University of Wisconsin Medical School, addressed the Society on the "Use of Anticoagulants in the Treatment of Thrombosis and Embolism."

The next meeting of the society will be in Racine in May 1949.

The First Modern Dentistry...

Dentistry, in the story of its evolution from "tooth tinkering" to modern methods, cites the jeweler's "fiddle-bow" drill as the first of America's mechanical devices for the preparation of cavities.

This and later nineteenth century technical developments—Lewis' hand drill with adjustable head, the finger thimble and hand bur, the first modern dental chair, the advent of sponge or crystal gold for fillings, improvements in the manufacture of porcelain teeth, etc.—were paralleled by developments in the educational field:

In 1826 Leonard Koecker's scholarly *Principles of Dental Surgery* presaged the demise of practicing laymen—a prophecy that ripened with the founding of the first dental college at Baltimore in 1840. Chapin A. Harris' *American Journal of Dental Science*, published in 1849, heralded the coming of other early educational and fraternal magazines, some of which still serve the profession today.

★ ★ ★

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News Items and Personals

Dr. A. H. Stahmer Named Trustee of College

Dr. Albert H. Stahmer, Wausau, was recently elected to the board of trustees of Baldwin–Wallace College in Berea, Ohio. Doctor Stahmer received his bachelor of science degree from Baldwin–Wallace College in 1930 and took his medical studies at Marquette University School of Medicine, graduating in 1935. He has been practicing in Wausau since that time.

Dr. J. H. Steiner Assumes Waupaca Practice

Dr. John H. Steiner recently took over the practice of *Dr. Henry Santina*, Waupaca, with whom he has been associated since early in 1948. Doctor Steiner, a graduate of Marquette University School of Medicine, served as a medical officer with the United States Navy during World War II. He located in Waupaca shortly after his discharge.

Dr. R. K. Salter Appointed to Surgical Residency

Dr. Robert K. Salter, Cadott, began a four year surgical residency at Columbia Hospital in Milwaukee on September 1. The doctor has been associated in practice with *Dr. C. E. Zenner* at Cadott since July 1947.

Hayward Physician Opens New Offices

Dr. E. R. Krueger, Hayward, on August 23 opened his new eleven room office building in that city. The building contains rooms for examination, consultation, x-ray work, laboratory work, emergencies, and sterilizing as well as a large reception room and dark room.

Dr. F. E. Turgasen Named Head of Manitowoc Hospital Staff

Dr. F. E. Turgasen was elected president of the medical staff of Holy Family Hospital, Manitowoc, at a regular monthly luncheon meeting on September 16. Doctor Turgasen succeeds *Dr. H. J. Belson.* Other officers named were *Drs. E. W. Huth*, Valders, vice-president, to succeed *Dr. C. J. Skwor*, Mishicot; and *R. S. Simenson*, secretary, to succeed *Dr. N. A. Bonner. Drs. R. G. Yost* and *N. A. Bonner* will serve on the executive committee with the current officers.

Roentgenologist Joins Staff of Sheboygan Hospital

Dr. William W. Moir, who has been a resident in radiology at the State of Wisconsin General Hospital for the past three years, recently joined the staff of Memorial Hospital in Sheboygan as a full time roentgenologist. Doctor Moir, a graduate of the University of Minnesota Medical School, served in the Army Medical Corps from 1941 to 1945.

Dr. E. W. Vetter Joins Fond du Lac Clinic

A specialist in general surgery, Dr. Edward W. Vetter recently became associated with the staff of the Fond du Lac Clinic in Fond du Lac. After five years of service in the Army Medical Corps, Doctor Vetter completed three years of postgraduate work at the New York Medical College and Memorial Hospital, New York, and at Mercy Hospital, Canton, Ohio. He is a graduate of Marquette University School of Medicine.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—Editor's Note

SOCIETY PROCEEDING

Dane

The Dane County Medical Society held a dinner-dance at the Maple Bluff Country Club in Madison on September 18.

Its annual golf tournament was held at the Nakoma Golf Club, Madison, on September 23, and was followed by dinner at the Country Club. Members of the Golf Committee were *Drs. D. M. Britton, N. M. Clausen, F. L. Hummer, J. C. Moore*, and *D. T. Schuele.*

THIRD DISTRICT NEWS

Drs. E. J. Nelson and J. A. Grab Join in Sun Prairie Practice

Drs. E. J. Nelson and *J. A. Grab* recently became associated in the practice of surgery, obstetrics, and gynecology in Sun Prairie. Doctor Grab entered

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practice in that community in 1941, and returned in 1946 after serving as the Wisconsin state medical officer for the Selective Service program. Doctor Nelson has been in practice with *Dr. L. W. Peterson* at Sun Prairie since 1939.

Dr. G. E. Oosterhous Joins Davis-Neff Clinic

G. E. OOSTERHOUS

Dr. George E. Oosterhous, a Madison pediatrician since 1939, recently joined the staff of the Davis-Neff Clinic as an eye specialist. A 1938 graduate of the University of Wisconsin Medical School, Doctor Oosterhous spent two years in the department of pediatrics at the State of Wisconsin General Hospital. He has been a member of the staff of the Dean Clinic in Madison since 1941.

Dr. Joseph Gamet Returns to Private Practice

Dr. Joseph Gamet, Janesville, has resigned his position as director of the Rock County Sanitary Unit in Janesville and returned to private practice in eye, ear, nose and throat work. Doctor Gamet, who began his work with the sanitary unit in July 1947, returned to Janesville in 1946, following six years of active duty with the Army Medical Corps.

Dr. J. W. Gale Attends Conference on Tuberculosis

Dr. J. W. Gale, Madison, attended the thirty-fifth annual Mississippi Valley Conference on Tuberculosis in Chicago, the week of September 19. Doctor Gale is a professor of surgery at the University of Wisconsin Medical School.

Dr. G. P. Fitzgerald Attends Ophthalmological Study Council

Dr. Gerald P. Fitzgerald of Janesville recently returned to that city after spending three months with the Ophthalmological Study Council in Portland, Maine.

Dr. H. H. Reese Speaks at Centennial Celebration

Dr. Hans H. Reese, professor of neuropsychiatry at the University of Wisconsin Medical School, was the guest speaker at the centennial celebration of the Medical Society of the State of Pennsylvania in Philadelphia on October 7. He presented a paper on "Open Pages in Neurology."

SOCIETY PROCEEDING

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society and the Eye, Ear, Nose, and Throat Section of the State Medical Society joined for a meeting at the Banquet Room of the Hotel Schroeder in Milwaukee on October 6. Following a luncheon, *Dr. Frederick A. Davis*, Madison, discussed "Cataract Extraction," illustrating his talk with motion pictures. Doctor Davis is professor of ophthalmology at the University of Wisconsin Medical School.

TWELFTH DISTRICT NEWS

Marquette Physicians Attend Course in Atomic Science

Three weeks of intensive study in the application of atomic science to the fight on disease were completed at the University of California late in August by *Drs. John S. Hirschboeck*, dean of Marquette University School of Medicine, and *Irving Cowan*, professor of radiology at Marquette. The knowledge gained at this session will be applied in the new atomic medicine laboratory opened this fall at Marquette. The Milwaukee university is one of twenty-nine midwestern medical schools that will become active in atomic medicine, working with isotopes from the federal atomic plant at Oak Ridge, Tennessee.

SOCIETY RECORDS

New Members

John E. Promer, 319 West Main Street, Waukesha.

Charles E. Wiley, Veterans Administration, Waukesha.

Walther W. Meyer, 130 South Third Street, Medford.

Eli A. Gecht, 8700 West Wisconsin Avenue, Wauwatosa.

Milton J. Lorin, Veterans Administration, Wood.

George J. Roncke, Veterans Administration, Wood.

William K. Hoffman, 3321 North Maryland Avenue, Milwaukee.

Charles L. Junkerman, 3321 North Maryland Avenue, Milwaukee.

James D. Sweeney, 3321 North Maryland Avenue, Milwaukee.

Gerald P. Lawrence, Veterans Administration, Wood.

William M. Pfeifer, 536 West Wisconsin Avenue, Milwaukee.

Charles P. Orr, 8700 West Wisconsin Avenue, Wauwatosa.

Thomas C. Puchner, 8500 West North Avenue, Wauwatosa.

Gerald E. Fox, Veterans Administration, Wood.

Leonard S. Robbins, 908 North Twelfth Street, Milwaukee.

Norman W. Osher, 324 East Wisconsin Avenue, Milwaukee.

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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.

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MARRIAGES

Dr. Thomas L. Calvy and Miss Rita Monroe, Wood, on August 28.

Dr. Rolf Poser and Miss Mary Groom, Columbus, on September 2.

DEATHS

Dr. R. C. Buchanan, well known physician who had practiced in Green Bay since 1896, died at a Green Bay hospital on August 21. He was 78 years old. A life member of the State Medical Society, last year he became a member of its Fifty Year Club.

The doctor was born in Florence, Ontario, Canada, on June 12, 1870. He entered Wayne University College of Medicine, Detroit, from which he received his medical degree in 1896. Shortly afterward, he established his practice in Green Bay.

Granted life membership in the State Medical Society in 1947, Doctor Buchanan was a member of the Brown–Kewaunee–Door County Medical Society. He recently became an affiliate fellow of the American Medical Association. He also held membership in the American College of Surgeons.

The doctor is survived by his wife.

Dr. William H. Drissen, widely known physician from Port Washington, died at a Port Washington hospital on September 10. Health officer of Port Washington for twenty years, the doctor had reached the age of 71 years.

A native of Kewaunee, Doctor Drissen received his degree in medicine from Northwestern University Medical School in 1911. Following graduation, he established his practice in Port Washington.

A past-president of the Washington–Ozaukee County Medical Society, the doctor was a member of the State Medical Society and the American Medical Association. He was also a charter member and past-president of the Rotary Club in Port Washington.

Survivors include his wife and two sons.

Dr. A. S. Horn, 67, physician at Rib Lake, died at his home in that community on August 22. He had been in practice in Rib Lake since 1941.

Doctor Horn, born in Atwood, Kansas, on August 23, 1881, received his medical degree from the University of Illinois College of Medicine in 1903. He practiced in Illinois and New Mexico before locating in Rib Lake. During World War I he served as an officer in the Army Medical Corps. For a number of years he served as health officer of Rib Lake village and township.

A major in the medical reserve of the United States Army, the doctor was a member of the American Legion and the Veterans of Foreign Wars. He also held membership in the Price–Taylor County Medical Society, the State Medical Society, and the American Medical Association.

The doctor is survived by his wife.

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Dr. James B. Vedder, well known physician from Marshfield, died at a Marshfield hospital on September 12. He was 65 years old.

Doctor Vedder, who was born in Walworth County on August 1, 1883, has resided in Marshfield since 1885. He attended Marquette University and received his medical education at Northwestern University Medical School, graduating in 1905. That same year he entered practice in Marshfield. In 1917 his brother, the late Dr. Harry Vedder, became associated in practice with him, and in 1920 they became members of the Marshfield Clinic. During World War I the doctor served with the Army Medical Corps in France.

Chief of staff of St. Joseph's Hospital in 1935, Doctor Vedder was a past-president of the Wisconsin Society of Obstetrics and Gynecology. He was also a member of the Wood County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife and three sons, two of whom are physicians at the Marshfield Clinic.

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Report of the 1947-1948 Auxiliary President

By MRS. A. W. HAMMOND

Beaver Dam

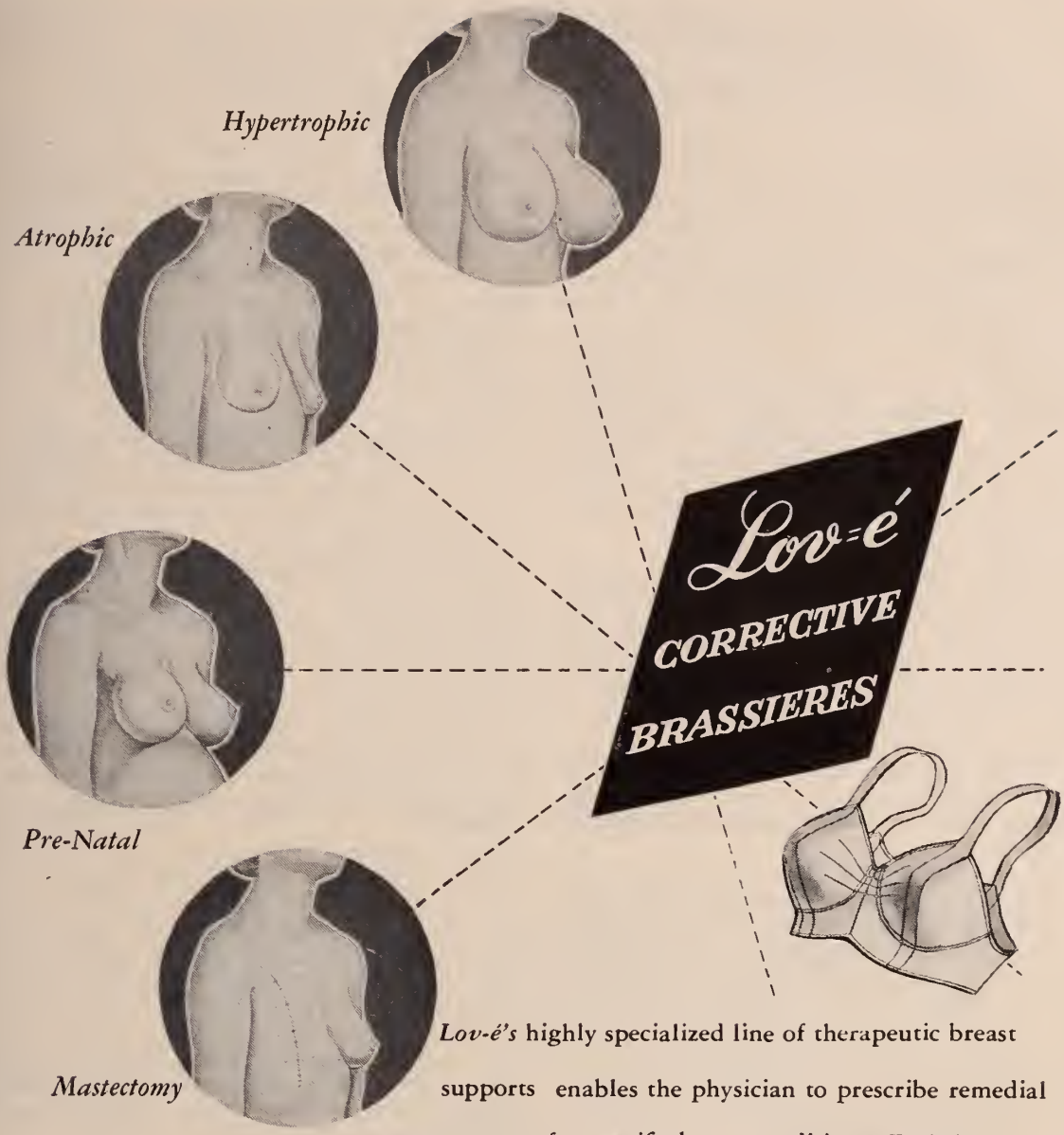
Mrs. A. W. Hammond
Beaver Dam
1947–1948 President

A YEAR, brief in time but unterminating in enriching awards, has passed since I took office as your president and presented these three over-all objectives for the twelve months ahead: (1) to be well informed, (2) to be vigilant, and (3) to be friendly.

It is because of traditional mandate that I now summarize the activities of these months—in abridged form—for I have always maintained that what we are going to do is far more important than what we have done.

As your representative I attended the Mid-Year Conference for State Presidents and Presidents-Elect and Members of the Executive Board of the Woman's Auxiliary to the A. M. A. held in Chicago, November 6 and 7, 1947; also the National Convention held in Chicago June 21–26; on August 13 acted as hostess at the Wisconsin Centennial Exposition in Milwaukee; sent telegrams to United States Senators Joseph McCarthy and Alexander Wiley requesting deletion of that part of the Draft Bill discriminating against doctors; talked at the All State Conference of the Wisconsin Division of the Cancer Society at Green Lake; gave a radio broadcast over WHA; toured the two Milwaukee County hospitals for the Mentally Ill as well as our own state hospitals to observe the care available to those hospitalized; and had an interview with the Honorable Oscar Rennebohm, our governor, to discuss procurement of a more adequate mental health service.

Twice I have been a guest of the Dane County, Fond du Lac County, and Milwaukee County Auxiliaries and once of the Dodge, Kenosha, La Crosse, Sauk, and Winnebago Auxiliaries.



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On February 4 our Mid-Year Board Meeting was held at the Hotel Schroeder, Milwaukee. In the morning a School of Instruction was conducted, and in the afternoon reports by state officers and chairmen were presented.

At the luncheon meeting Dr. W. D. Stovall, president of the State Medical Society, talked on "The Wisconsin Physicians Service." In an absorbing manner Doctor Stovall sketched pioneer medical practice and lucidly contrasted the Voluntary Medical Care Plan used in Wisconsin with the Compulsory Medical Care Plan being agitated by some factions today.

Mrs. Eustace A. Allen, our national president, and Mrs. James P. Simonds, national chairman of publications, were our guests at this conference. Mrs. Allen visited us during our fall meeting a year ago. Such visits are of incalculable value, for they are a contributing factor to the molding of our membership into a nation-wide organization militated for the good of the medical profession.

As of June 1, our membership totaled 1,171, an increase of 75 over the previous year. One hundred and twelve new members were admitted. The variance between this and the preceding figure is due to deaths, resignations, and non-payment of dues. For the first time the names of our members were published in *The Wisconsin Medical Journal.*

Two of our members, Mrs. Robert Fitzgerald and the late Mrs. Eben J. Carey, each of whom served as state and as national president, were signally recognized when we bestowed honorary membership upon them.

In giving support to the Nurse Recruitment Program we have urged that an attempt be made to deglamorize this profession, for we have learned that many trainees, disillusioned by the outward attractive aspects of this pursuit and uninformed about the attendant strenuous training, drop out after the first few weeks of schooling.

An activity which I feel confident will have tangible results has been our promotion of a program of improved care for our mentally ill, one of our major objectives for the year.

With apologies for undiplomatically singling out the activities of some of our constituent units, I want to speak of certain events because of their direct bearing upon this important project.

The past spring the Winnebago County Auxiliary was hostess to the Fond du Lac County group at a luncheon meeting at the Winnebago State Hospital for the mentally ill. There the members were able to observe the good care the patients received under the skilled guidance of Dr. Byron J. Hughes, superintendent, in spite of the regrettable lack of a well trained personnel, inadequate housing, and antiquated equipment. Those of us who had toured the hospital previously marveled at the transformation wrought by recent redecorating. The renovation was made possible by appropriations granted by our state legislators. We have been told that the obtaining of these funds can be credited, at least in part, to the united zeal of the women of our state. That should be an incentive to strive with continued fervor to secure funds sufficient for a larger and better qualified personnel.

A few weeks later a striking contrast in legislative grants was revealed when the Fond du Lac County Auxiliary reciprocated by entertaining the Winnebago County members at a luncheon meeting at Taycheedah, the State Home for Women. There we saw what to all appearances seemed an ideal set-up—sufficient and attractive housing and a highly qualified staff. This much-to-be-desired adequacy bespeaks the willingness of our legislators to grant appropriations necessary for the maintenance of such an institution. I commend them for their sagacity.

However, when we have asked for funds essential for the care of our mentally ill, the good judgment of most of our legislators has been as diametrically the opposite as possible. Our mentally ill truly are our forgotten citizens.

During this year considerable progress has been made toward better housing. The Mendota Hospital, used for several years by the federal government for the veterans, has been restored for use by the state. Ground has been broken for a large addition to Winnebago.

Desirable and urgent as this is, it is not the entire solution to this problem. We must have a larger and more skilled personnel to man these hospitals, or the care of the patients will be for the most part custodial.

Here a challenge faces us. I am glad to report that the initial steps to meet this challenge have been taken.

In May the Outagamie County Auxiliary sponsored a panel discussion presented by experts in the field of mental health. So outstandingly successful was this meeting that it is now being used as a pattern for similar meetings in key cities throughout the state. Our county auxiliaries have been asked to sponsor these panels and to cooperate with the Wisconsin Society for Mental Health, which is engineering the plans.

This is a program in which I urge every member to continue to participate. We have reached the point where we must take decisive action so that provision will be made for larger professional staffs at our hospitals. Sufficient funds will be forthcoming when the budget for the 1949 legislature is drafted if we do not shirk our duty.

When the right time comes it is mandatory that we contact, in person if possible, our legislators so that we will gain their support for these budgetary requests. Because the legislators are our representatives and we are their constituents, the outcome looks promising.

There is something else of grave importance in the immediate future.

Next month an important election will be held. When we make our cross on the ballot we should let prudence dictate. It seems to me that we are ap-

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proaching a pivotal point in the practice of medicine. We will either continue with the voluntary medical service plan or have a compulsory system forced upon us.

Recently in a newspaper release it was stated that possibly the Wisconsin Physicians Service Plan was the most workable, the most satisfactory to-date.

Are we to be deprived of this service? Are we to have some plan tantamount to socialized medicine thrust upon us?

We may, if we fail to exercise our voting franchise intelligently. Our indifference, our apathy, may cause us to lose that precious heritage, the right of free enterprise.

We do approach the pivotal point!

Before we mark our ballot in any election, we, as doctors' wives should ask, "What position does this candidate for city council take on a sound public health program? What stand does this candidate for the United States Senate take on a compulsory medical care plan?"

We must be well informed! We must be vigilant! Stirred with inflammatory elan, we can be the implement whereby only bills fair and just to both the medical profession and to the people become law.

A year is all too short a time to make a breath-taking record. But in spite of the lack of luster in this resumé, I want you to know that it has been a year brimming over with many good things that I will always treasure.

To Dr. Stephen E. Gavin, our councilor, I am deeply indebted for his ever-ready advice, to Dr. W. D. Stovall, president of the State Medical Society for his never failing cooperation, and to Mr. C. H. Crownhart and his entire staff for their splendid assistance.

To the national officers and chairmen and to Miss Margaret Wolfe, executive secretary, I extend my thanks for their much needed help.

And now to the past presidents, the officers and chairmen of standing committees, the county auxiliary presidents, and the members, and to the convention chairman and her corps of assistants I offer my sincerest appreciation and thanks.

You are the ones who have made the year replete with the joy of working together toward a great goal. You are the ones who have made the year overflowing with the pleasure of experiencing your unexcelled hospitality when I have been your guest and with the delight of making new friends.

These warm friendships, running deep like a blue stream and cemented by the bond of the profession, I will always cherish. To have served you and to have served a profession which is the epitome of altruism, has been a great privilege and a great honor. Proudly and gladly have I done so.

I am confident that you hold in store for my successor this same fine spirit of good fellowship and of cooperation for which I am so exceedingly grateful.

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Sexual Behavior in the Human Male. By Alfred C. Kinsey, Professor of Zoology, Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; and Clyde E. Martin, Research Associate, Indiana University. Pp. 804. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.50.

Probably no single text or volume of any kind that has been written within modern times has been the target of so much comment, both good and bad, and so much criticism, as the report on "Sexual Behavior in the Human Male," by A. C. Kinsey and his associates, W. B. Pomeroy and C. E. Martin of Indiana University. It is extremely doubtful that the president of our sister Indiana University and the dean of its Graduate School, the trustees and others of the administrative group, along with the Rockefeller Foundation through its director for the medical sciences, would have so thoroughly endorsed and encouraged and supported the study if it had been felt that it were an undesirable and morally unacceptable investigation. Those who attack the report as offensive to good taste must go back into this group certainly as aiding and abetting the Kinsey, et al. delinquency.

The study is based upon the sexual histories of 5,300 males. The authors indicate in their acknowledgments that "These persons represent each and every age, from children to the oldest groups; they represent every social level, of several racial groups." The authors have made no claims about giving the final and axiomatic status of the male so far as his sexual propensities are concerned. They merely give the report and conclusions which they have formulated upon the basis of their studies of these 5,300 males coming principally from about a dozen states in the northern part of this country. It has been worked out as a strictly statistical study, scrupulously avoiding the slightest personal influence or opinion. The numerous tables and graphs are conclusive in themselves. The approach to the subject has been taxonomic.

The total sexual outlet has included six chief sources of orgasm. The frequency, the distribution, and the outlet in the various age groups, along with the changes in frequency resulting from the aging process, and the general patterns of the various educational levels reveal some exceptionally interesting facts for those who will take the time to study the text. Certainly it should be in the hands of judges, physicians, and parole officers, as well as many others in positions requiring understanding and well tempered judgment. It cannot be read lightly, but, for the individual who assiduously studies the material, it will certainly provoke thought and increase understanding and insight into the emotionally beclouded and misunderstood matter of sexual behavior. The study is a statistical and taxonomic classic, but certainly dull and disappointing for the usual purposes of light fiction.—L. R. C.

Handbook of Psychiatry. By Winfred Overholser, A. B., M. D., Sc. D., Superintendent, St. Elizabeth's Hospital; Professor of Psychiatry, George Washington University, Washington, D. C.; and Winifred V. Richmond, B. S., A. M., Ph. D., Late Chief, Department of Psychology, Saint Elizabeth's Hospital; Late Consultant in Psychology, New Mexico State Department of Welfare. Pp. 252. Philadelphia, London, and Montreal; J. B. Lippincott Company, 1947. Price $4.00.

This book is written for the layman in a simple and unsensational manner. The authors have attempted to give an understanding of mental illness. In addition to a discussion of the various types of mental disorders, there are separate chapters on special problems, e.g., "Crime and Mental Disorders" and "Mental Aberrations and War." Psychiatric conditions in children receive special attention, and the importance of this field of psychiatry is adequately stressed. The last chapter deals with the contributions that the layman can make to further the goals of psychiatry especially prevention through mental hygiene.

In a time when the public has become very conscious of psychiatric problems which are presented on the screen, over the radio, and in magazines, often in a sensational and distorted manner, this book fills a definite need. It furnishes sound information and is to be highly recommended.—F. K.

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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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Neuroanatomy. By Fred A. Mettler, A. M., M. D., Ph. D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University, New York. Pp. 536, with 357 illustrations. Second Edition. St. Louis, The C. V. Mosby Company, 1948.

This second edition is much like the original edition in its organization, but is improved by an extended account of the blood supply of the various parts of the neuroaxis. The chapters on the thalamus have also been extended to include the more recent advances in our knowledge of the structure and functional connections of the thalamic structures.

The text as a whole is profusely illustrated with many very instructive figures. Part I, on the "Gross Anatomy of Nervous System," is treated in a conventional manner and is well arranged.

Part II, on the "Microscopic Anatomy," is partly in atlas form with a textual description of selected sections through the brain stem, and partly a discussion of the structure and function of certain structures. A separate chapter is allotted to each fundamental division of the brain stem. One of the criticisms that may be made is that the content of each chapter is not confined to the specific division of the brain stem. Thus, for example, the chapter on the medulla contains the description of the cerebellum and the chapter on the mesencephalon contains paragraphs on the cerebellar mechanisms and on the physiology of the cerebellum, whereas the chapter on the pons (metencephalon), to which the cerebellum belongs is silent, on the subject. It is confusing at least to the beginning student of neuroanatomy to read, for example, Chapter XIII, entitled "Mesencephalon" and find that after a description of three sections through the lower mesencephalon the discussion turns to the following subject: "Summary of the Region of the Pons, Audition, Vestibular Function, The Reticulospinal Systems, Cerebellar Mechanisms, Physiology of the Cerebellum, Fifth Nerve, and Systems of the Pontine Region." The chapter is then concluded with a description of three more sections through the upper part of the mesencephalon and then a review of the mesencephalon.

As a whole the text contains much detailed information.—T. H. B.

Clinical Hematology. By Maxwell M. Wintrobe, M. D., Ph. D., Professor of Medicine, University of Utah, School of Medicine, Salt Lake City; Formerly Associate in Medicine, Johns Hopkins University, Associate Physician, Johns Hopkins Hospital, and Physician-in-Charge, Clinic for Nutritional, Gastro-Intestinal and Hemopoietic Disorders, Baltimore. Second edition. Pp. 862, with 197 engravings and 14 plates, 10 in color. Cloth. Philadelphia: Lea & Febiger, 1946. Price $11.00.

This second and enlarged edition is one of the best books published in any of the branches of internal medicine and certainly holds top rank amongst the several on hematology published in recent years. It is very complete, carefully compiled, and remarkably up-to-date. There are discussions of very recent aspects of hematology such as the use of folic

acid, the Rh factor in hemolytic disease of the newborn, the use of nitrogen mustards in Hodgkin's disease, and related conditions. Every subject is well handled; the reviewer was especially impressed by the sections on the anemias and on sickle cell anemia in particular. The basic physiologic and chemical aspects as well as the clinical facts of hematology are ably discussed. The bibliography is very extensive and well chosen.

Some of the color plates are excellent, others are only fair. The discussion on variations of the platelets in disease on page 195 is not as complete as it might have been, and this is a subject which generally is not given the attention it deserves. The classifications of the hemorrhagic diseases and of the anemias are rather complicated and very detailed. Simpler classifications, perhaps based on etiologic grounds, although certainly no more accurate, would seem to be more practical.

All in all, this volume furnishes a tremendous amount of practical data, authoritatively presented. The author, an outstanding American hematologist, and the publishers are to be congratulated upon a very successful endeavor.—O. O. M.

The Medical Clinics of North America. New York Number. Symposium on Pediatrics. Pp. 783. Philadelphia and London: W. B. Saunders Company, 1947.

In the reviewer's opinion, this symposium is one of the best clinics ever published by W. B. Saunders and Co. All of the contributors are outstanding in their particular fields of interest.

New advances in the diagnosis and management of neoplastic diseases, asthma, rheumatic fever, Rocky Mountain spotted fever, endocrine disorders, syphilis, and poliomyelitis are well presented. Reviews of the subjects of the Rh factor, the effect of maternal diet in the intrauterine fetus, and the most recent concepts of the use and value of active and passive immunization procedures add much to the value of the book. Excellent papers on the importance of urologic examinations, ophthalmologic problems, bone marrow studies in diseases of the blood, and feeding problems encountered in children are included. To remind us of the importance of recognizing mental as well as physical illness in young subjects, behavior disorders and childhood schizophrenia are discussed.

This symposium is highly recommended because of the wide range of fine subject matter which makes it of especial value to the practitioner of medicine.—K. B. McD.

Encyclopedia of Medical Sources. By Emerson Crosby Kelly, M. D., F. A. C. S., Associate Professor of Surgery, Albany Medical College; Attending Surgeon, Albany Hospital; Editor, Medical Classics. Pp. 476. Baltimore: The Williams and Wilkins Company, 1948. Price $7.50.

This "labor of love" presents an enormous amount of information on sources of medical terms and discoveries. The main arrangement is alphabetic by author, but a subject index is also included. The author makes no pretensions to completeness, nor

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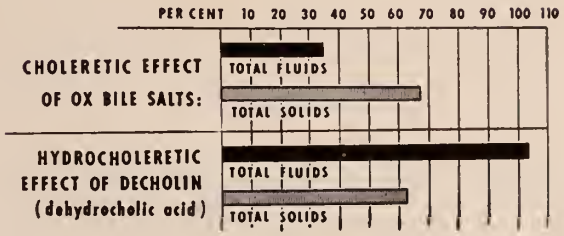

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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does he attempt to "pin down the first description of any condition." Some idea of the degree of completeness may be suggested by the fact that 79 names are given under the subject "Test for glucose (sugars)," 12 under the subject of the "vagus nerve," and none under the "Rh factor," although under Landsteiner, a reference is given to the first paper on the subject. The book will be a distinct aid to authors.—P. F. C.

Principles and Practice of Obstetrics. By Joseph B. DeLee, M. D., Late Professor of Obstetrics and Gynecology, the University of Chicago; Consultant in Obstetrics, the Chicago Lying-in Hospital and Dispensary; and J. P. Greenhill, M. D., Attending Obstetrician and Gynecologist, the Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, the Chicago Lying-in Hospital; Chairman, Department of Gynecology, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Ninth edition. Pp. 1011, with 1108 illustrations on 860 figures, 211 of which are in color. Philadelphia and London: W. B. Saunders Company, 1947. Price $10.00.

The ninth edition of the Principles and Practice of Obstetrics edited by Dr. J. P. Greenhill has been extensively revised and maintains its standard as one of the outstanding publications in obstetrics, both from the teaching standpoint and as a reference for the practitioner in obstetrics. I recommend this book with no degree of hesitation to those interested in obstetrics.—R. E. C.

The Medical Clinics of North America. Nationwide Number. Philadelphia and London: W. B. Saunders Company, 1948.

The content of this issue is limited to discussions of various aspects of gastrointestinal disease, and the authors are drawn from three major centers, at Stanford, the Cleveland Clinic, and the University of Toronto. The articles in general adhere to standard practice and theory in regard to the diseases discussed and might well serve as an up-to-date review of these subjects for those who feel in need of such refreshing. One quite interesting article is by Dauphinee and Campbell on their studies of serum protein distribution in hepatic disease by electrophoretic methods. While little practical significance to the average clinician who does not have facilities for such study, it is a good presentation of one of the newer and more valuable tools in the study of hepatic disease and should prove of considerable theoretic interest to all who read it.—J. L. S.

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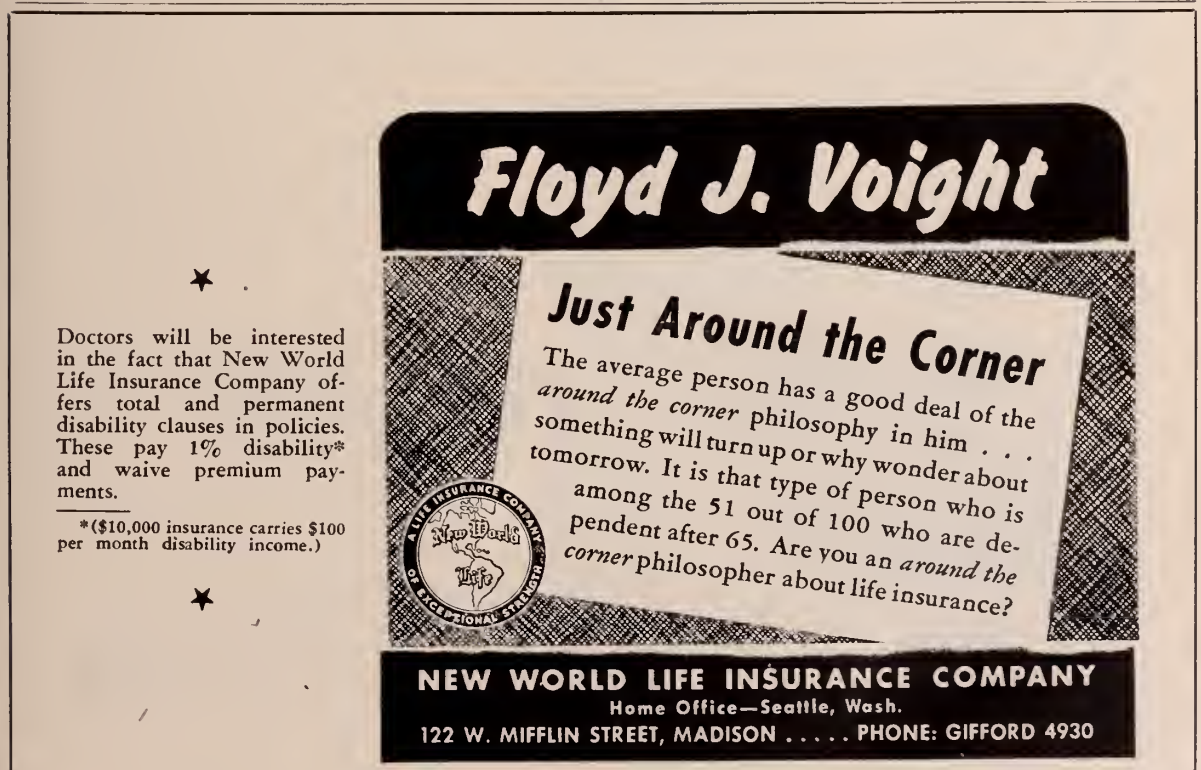
War, Politics, and Insanity. By C. S. Bluemel, M. A., M. D., F. A. C. P., M. R. C. S. (Eng.). Denver, Colorado, The World Press, Inc., 1948.

The author has made the attempt to analyze the problem of political leadership and the cause of war. He poses the question: What urges a man into the political field and what creates in him the desire to dominate the lives of other men? What are the distinguishing traits of personality that make his urge effective? Studying the biographies of several political leaders, the author comes to the conclusion that the pattern of the successful politician consists in high dominance drive invariably associated with obsessive-compulsive tendencies. An obsessive-compulsive pattern he apparently believes to find in most men who have pursued a goal successfully and tenaciously. He mentions Columbus, Perry, Amundson, Lindberg, the Wright brothers, and others. One of the cardinal causes of war, in the opinion of the author, is the fact that national leadership frequently falls to men of abnormal mental make-up. Aggression and obsessive-compulsive behavior form a dangerous combination. To avoid abnormal leadership the author outlines his ideas on "selective government." The legislative body as well as the cabinet is selected by lot from the senior citizens. Qualifications for senior citizenship are university education with a major study of history, economics, psychology, and related subjects fundamental to the understanding of men and government; as further qualifications—certification by the faculty as apparently free from abnormal traits of personality, such as paranoid trends, depressive moods, and undue aggressiveness.

The book serves the useful purpose to focus attention on political leadership as a psychologic problem. However, the treatment of this problem is oversimplified. Psychiatric terms like "paranoid" and "obsessive-compulsive" are used loosely. The obsessive-compulsive pattern is essentially different from the pursuit of goals with tenacity, perseverance, or fanaticism as demonstrated by the examples the author gives. Sweeping statements are made which are in contradiction to the material the author presents. For example: "The political leader if of course an extrovert, while the men he dominates are large introverts."—F. K.



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COMING EVENTS

National Society For Crippled Children and Adults to Convene in Chicago

The twenty-eighth annual convention of the National Society for Crippled Children and Adults, Inc., will be held at the LaSalle Hotel, Chicago, on November 15 to 17.

Many outstanding speakers in the fields of medicine, health, and education will be present to discuss the progress in work with the handicapped during the past year.

The convention will be attended by physicians, therapists, educators, workers with the handicapped, and representatives of more than 2,000 state and local units of the group throughout the United States, Canada, Alaska, and Hawaii.

American Board of Ophthalmology Announces Dates For Examinations

Applications are now being accepted for the 1950 written qualifying test for the American Board of Ophthalmology. Applications for the tests, which are held annually, will be considered in order of receipt until the quota is filled. Practical examinations for acceptable candidates in 1949 will be held in San Francisco, March 21–24; New York, June 11–15; St. Louis, October 15–19; and Boston, some time during December.

A supplementary list of diplomates from January 1948 to January 1949 will be sent without charge to all purchasers of the Board's directory.

University of Michigan Schedules Postgraduate Courses For 1949

The University of Michigan Medical School has scheduled two postgraduate courses for January 1949, the first to be a presentation of the application of the basic sciences to clinical medicine and the second a urology conference.

The first course, which will be held January 3–29, will correlate the basic sciences with clinical medicine. The lectures will cover the phases of chemistry, physiology, bacteriology, pathology, and pharmacology which are directly applied in the practice of internal medicine as well as clinical medicine. Daily ward rounds in small groups will offer practical demonstrations with patients and emphasize problems in physical diagnosis. Clinical conferences with pharmacologists, bacteriologists, and pathologists will further aid in the correlation.

The two day postgraduate program in urology and related sciences is being offered on January 19

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and 20 under sponsorship of the Detroit Urological Society. The lectures and clinics have been selected to interest the specialists in both practice and basic knowledge of urology. Registration will open at 9 a. m. on January 19 in the Rackham Building.

Requests for information should be directed to Howard H. Cummings, M. D., Chairman, Department of Postgraduate Medicine, University Hospital, Ann Arbor, Michigan.

American Academy of Dermatology and Syphilology Announces Convention Dates

The seventh annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago, December 4–9, it is announced by Dr. Earl D. Osborne, secretary–treasurer of the Academy, 471 Delaware Avenue, Buffalo, N. Y.

The principal sessions will be held at the Palmer House, with special courses in histopathology and mycology scheduled for December 4 and 5, at the medical schools of the University of Illinois and Northwestern University. As in the past two years, teaching clinics will be held on the afternoons of Monday, Tuesday, and Wednesday, December 6, 7, and 8. A new feature is being added to the program this year consisting of informal discussion groups, which will be held at noon and 5:00 p. m. sessions.

Extensive scientific and technical exhibits will be set up in connection with the meeting.

Special courses in histopathology, mycology, x-ray and radium therapy, mucous membrane lesions, bacteriology of the skin, industrial dermatoses, specific granulomata, and dermatoscleroses will be held under leaders in these various fields.

Special lectures will be given on: "Certain Aspects of Blood Dyscrasias of Special Interest to Dermatologists," by Dr. Cyrus C. Sturgis, chairman of the department of internal medicine, University of Michigan Medical School; "The Relation of Endocrines to Cutaneous Diseases," by Dr. Arthur A. Hellbaum, professor of pharmacology, University of Oklahoma School of Medicine; and Dr. E. C. Keaty, research associates of pharmacology and dermatology, University of Oklahoma, School of Medicine.

Other officers of the Academy are president, Dr. Clyde L. Cummer, Cleveland; Vice President, Dr. Francis E. Senear, Chicago; and assistant secretary–treasurer, Dr. John E. Rauschkolb, Cleveland.

South Atlantic Association of Obstetricians and Gynecologists Establishes "Foundation Prize"

The South Atlantic Association of Obstetricians and Gynecologists has announced the establishment of "The Foundation Prize." Authors of papers on obstetric or gynecologic subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N. E., Atlanta, Georgia.

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TRADE NEWS

Schering Announces New Research Grants

Five new research studies in the field of hormone therapy, x-ray diagnostics, and allergy, instituted under grants from the Schering Corporation, were recently announced by Mr. Francis C. Brown, president of the company. These grants in support of studies at four Eastern and one Western medical institutions are a part of the expanding program of research of these manufacturers.

An unusual study on encephalography in allergic children and the effect in this condition of Trimeton, a new antihistaminic, will be pursued at the New York Post-Graduate Hospital.

Companion studies on the utilization and absorption of the female sex hormones, progesterone, estradiol, and estradiol benzoate, by routes other than injection, will be studied at Cornell University Medical College and New York Medical College.

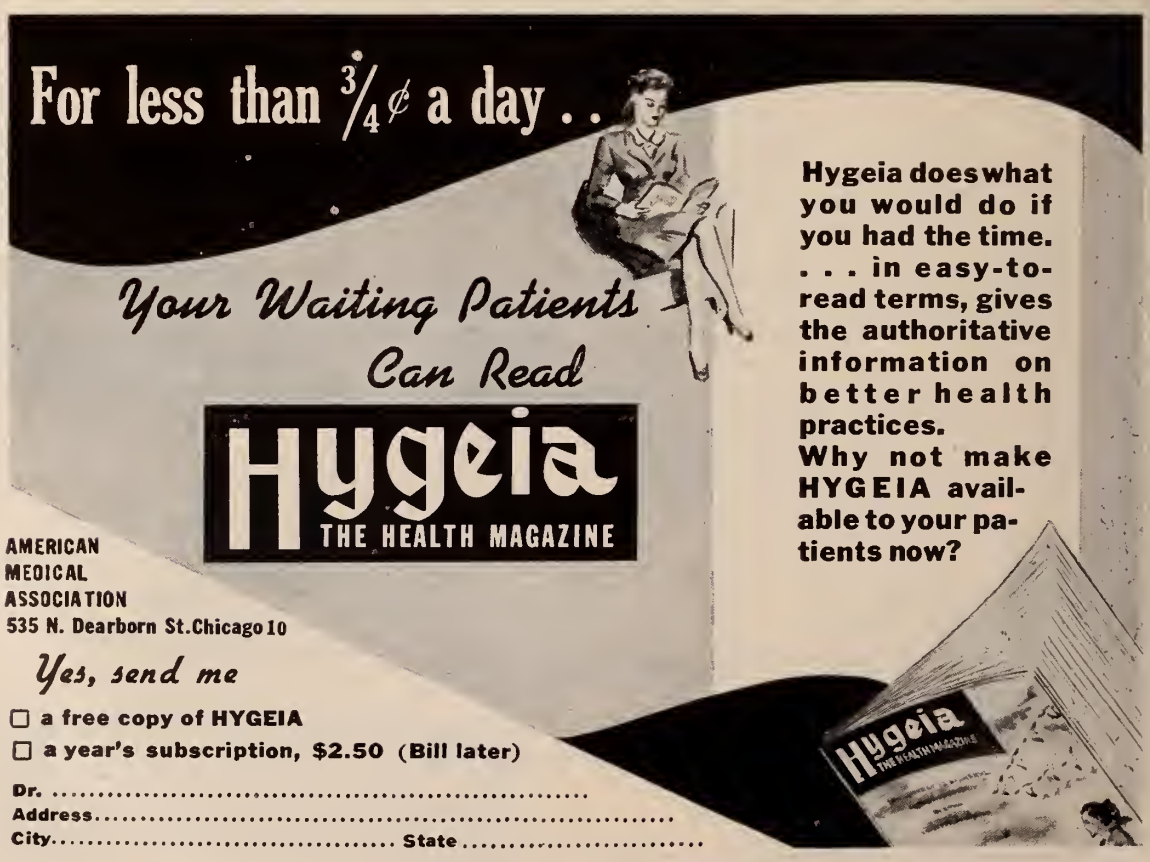
At Yale University School of Medicine, the metabolism, absorption, and excretion of the gall bladder diagnostic agent, Priodax, and of related compounds will be studied.

Studies on the effect of the male hormone preparations of testosterone in thyrotoxicosis, Addison's disease, and Cushing's disease will be presented at the University of Washington School of Medicine, Seattle.

New Tests Prove Worth of Ancient Medicine

Senna, one of the oldest botanical medicines in the world, has been subjected to new tests, which prove that its potency can be assayed and which demonstrate that preparations containing it may now be standardized and requirements established in official compendia. The tests on laboratory animals and human beings have been completed at the Sterling–Winthrop Research Institute, Rensselaer, N. Y., and the first report on them was presented in August at the American Pharmaceutical Association meeting in New York.

Senna was introduced into medicine in the ninth century and has been continuously used since, chiefly in laxative preparations. Although the United States imports nearly 1,350,000 pounds of senna leaf annually for use in thousands of medical preparations, no adequate attempt has been made to set up potency standards for any of the forms commonly seen in pharmaceutical commerce.



The studies arose out of the necessity for determining the potency of senna preparations in connection with developmental work. The material under study consisted of experimental and commercial batches of proprietary preparations containing about 50 per cent sugar and senna extractives equivalent to 50 to 100 mg. of fresh drug per cubic centimeter.

To obtain dose-response data, the investigators used adult male white mice. In a typical experiment five groups of 22 mice were set aside and each group received a different dose each test day. It was found that the responses fell into a normal pattern, so that conventional statistical technics could be applied to calculate the results and that the quantity necessary to produce a laxative effect in 50 per cent of a group did not fluctuate significantly from day to day. Having demonstrated that mice revealed differences in potency in preparation known to differ in age, method of manufacture, or actual senna content, experiments were conducted to test similar differences in human beings. Results were in "almost incredibly good agreement with the results obtained on the same preparations in mice."

It was concluded that the application of these findings will make possible the establishment, without difficulty of specifications for potency of senna in its various pharmaceutical forms. If this is done, a reference standard senna will be needed. Data are in hand which demonstrate the feasibility of this course, which can be adopted by official regulatory bodies.

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	983
Ames Company, Inc.	1044, 1045
Audiphone Utilities	1055
Ayerst, McKenna & Harrison	986
Barr X-Ray Co.	1053
Bellevue Place	1055
Benson Optical Co.	1043
Bergmann Prescription Pharmacy	1039
Camel (R. J. Reynolds Tobacco Co.)	981
Camp, S. H. & Co.	976
Central Drug	1046
Ciba	1059
Coca Cola Co.	1048
Coleman and Bell	1047
Continental Casualty Company	972
Cook County Graduate School of Medicine	1054
Doerflinger's	1055
Endocrine Laboratories	1055
First Central Dispensary	1039
Hotel Schroeder	973
House of Bidwell, Inc.	1053
Hurley X-Ray Co.	1055
Ivanhoe Treatment, Inc.	1043
Jensen Brothers	1046
Kennedy–Mansfield Dairy	1056
Lakeside Laboratories	982
Lilly, Eli and Company	facing page 987
Lov-é Brassieres	1037
M & R Dietetic Laboratories, Inc.	985
Mallatt Pharmacy	1039
Mather Pharmacy	1046
Mayer Drug	1046
Mead Johnson & Co.	978, 1058
Medical Protective Co.	1029
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Orthopedic Appliance Co., Inc.	1055
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Physicians Casualty Assn.	1054
Physicians Radium Assn.	973
Pogue, Mary E., School	1053
Prescription Pharmacy	1039
Professional Budget Plan	*Forum* 7
Professional Business Service	*Forum* 5
Radium Service Corporation	1050
Rennebohm Drug Stores	1039
Rentschler Floral Co.	1056
Roemer's	1050
Rogers Memorial Sanitarium	1060
Sacred Heart Sanitarium	1040
St. Croixdale Sanitarium	973
Schering Corporation	979
Schlintz Bros. Drug Store	1046
Searle, G. D. & Co.	1027
Shorewood Hospital Sanitarium	1031
Smith–Dorsey Company	974
Smith, Kline and French	1035
Squibb	975
Summit Hospital	1039
Swift and Company	984
Time Insurance Company	*Forum* 3
Upjohn	977
Wander Co.	1041
Winthrop–Stearns, Inc.	1033

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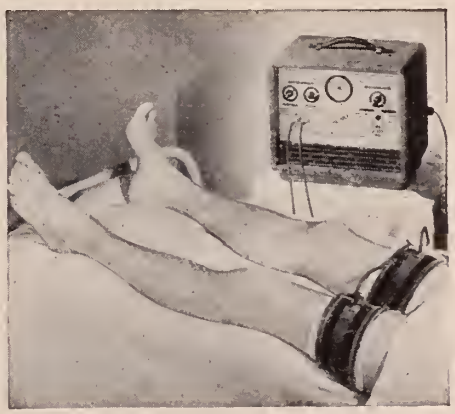

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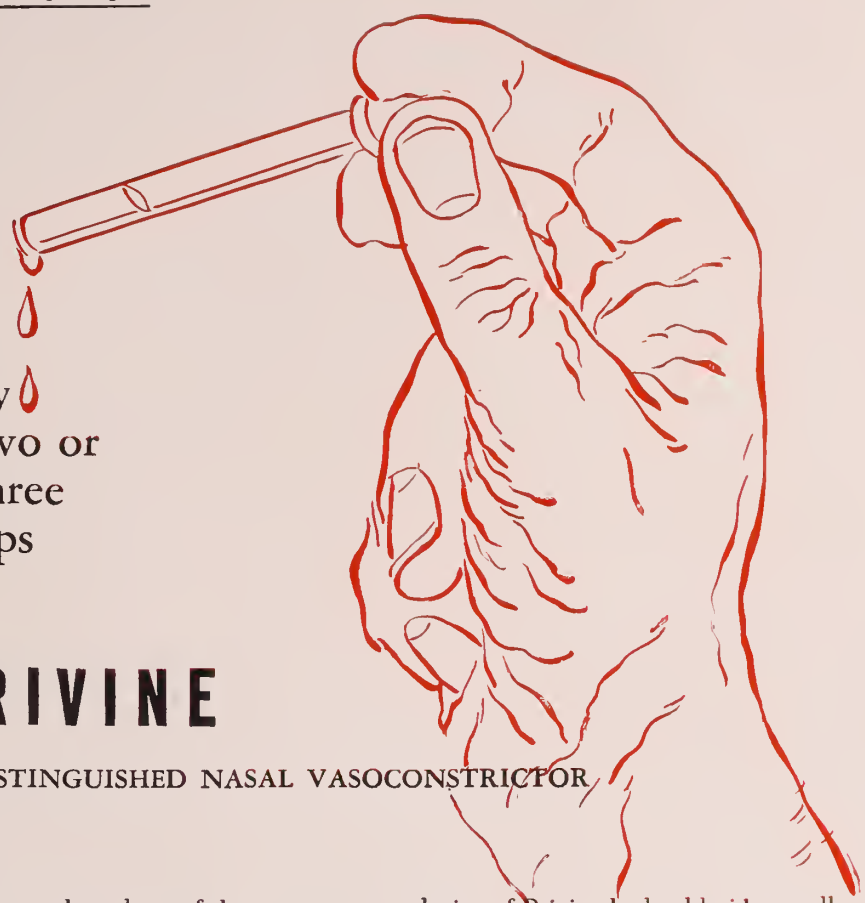

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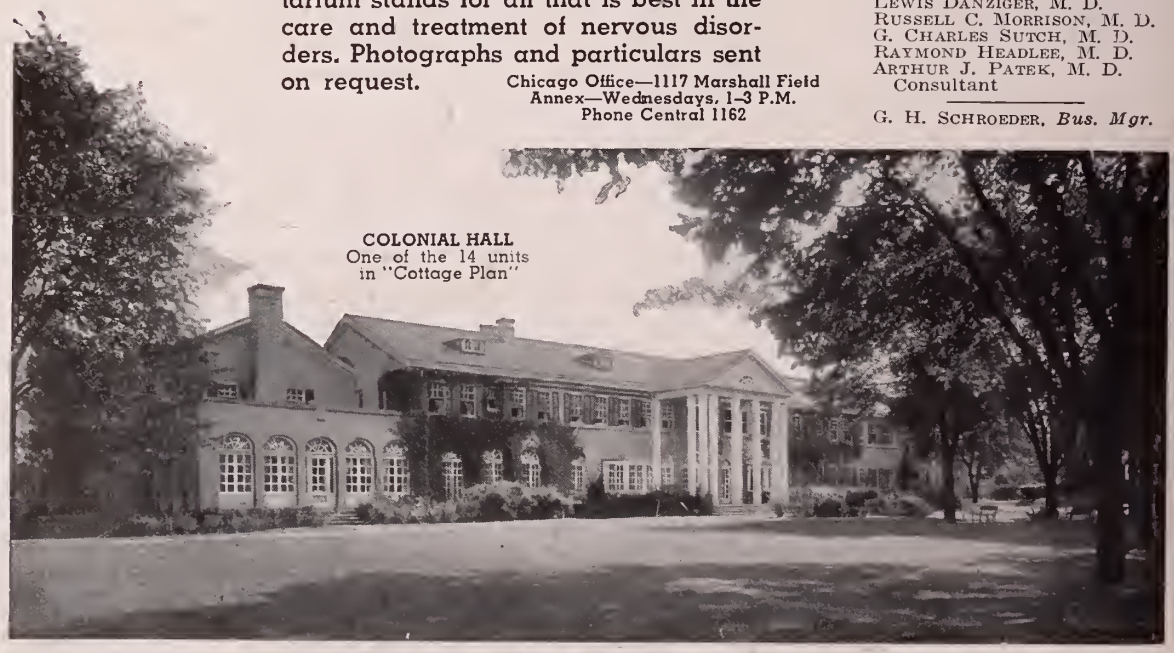

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Some Thoughts of an Incoming President, by Karl H. Doege, M. D., Marshfield	1079
Anesthesiology for Wisconsin, by William Kreul, Racine	1081
Experiences with Sympathectomy in Peripheral Vascular Disease, by James M. Sullivan, M. D., Milwaukee, and Willard B. Ross, M. D., Wood	1083
The Treatment of Mercury Poisoning with B. A. L. and Peritoneal Irrigation, by B. J. Longley, M. D., Madison	1089
Bronchogenic Carcinoma; the Cytologic Diagnosis from Bronchial Aspirations, by Lawrence L. Swan, M. D., New Orleans	1092
Benign Multiple Hemangiomas, by Joseph M. King, M. D., Jack A. Klieger, M. D., and Leo R. Weinshel, M. D., Milwaukee	1095
Some Modern Aspects of the Treatment of Bulbar Poliomyelitis, by H. D. Bouman, M. D., and K. B. McDonough, M. D., Madison	1099
Comments on Treatment	1103
Notes on Clinical Pathology	1104
As It Looks to Your State Board of Health	1105

EDITORIAL

	Page
Vivisection and Research, by Conrad A. Elvehjem, Ph. D.	1109

MISCELLANY

As Seen from the Countryside	1106
The President's Page	1107
Society Proceedings	1110
News Items and Personals	1112
And About the Third and Twelfth Districts	1114
Society Records	1116
Marriage	1118
Births	1118
Deaths	1118
The Woman's Auxiliary	1122
The Journal Bookshelf	1126
Coming Events	1134
Physicians' Exchange	1138
Index to Advertisers	1140
List of Executive Officers of County Medical Societies	1141

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med.; Vol. 35, 6-1-25, No. 11, 590-592.

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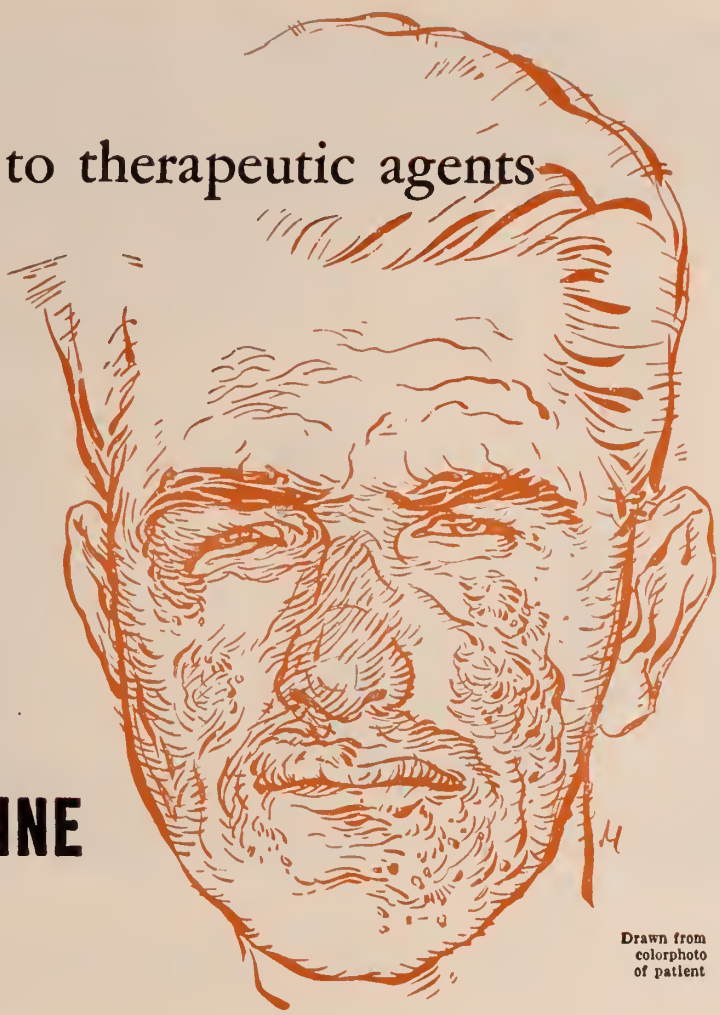

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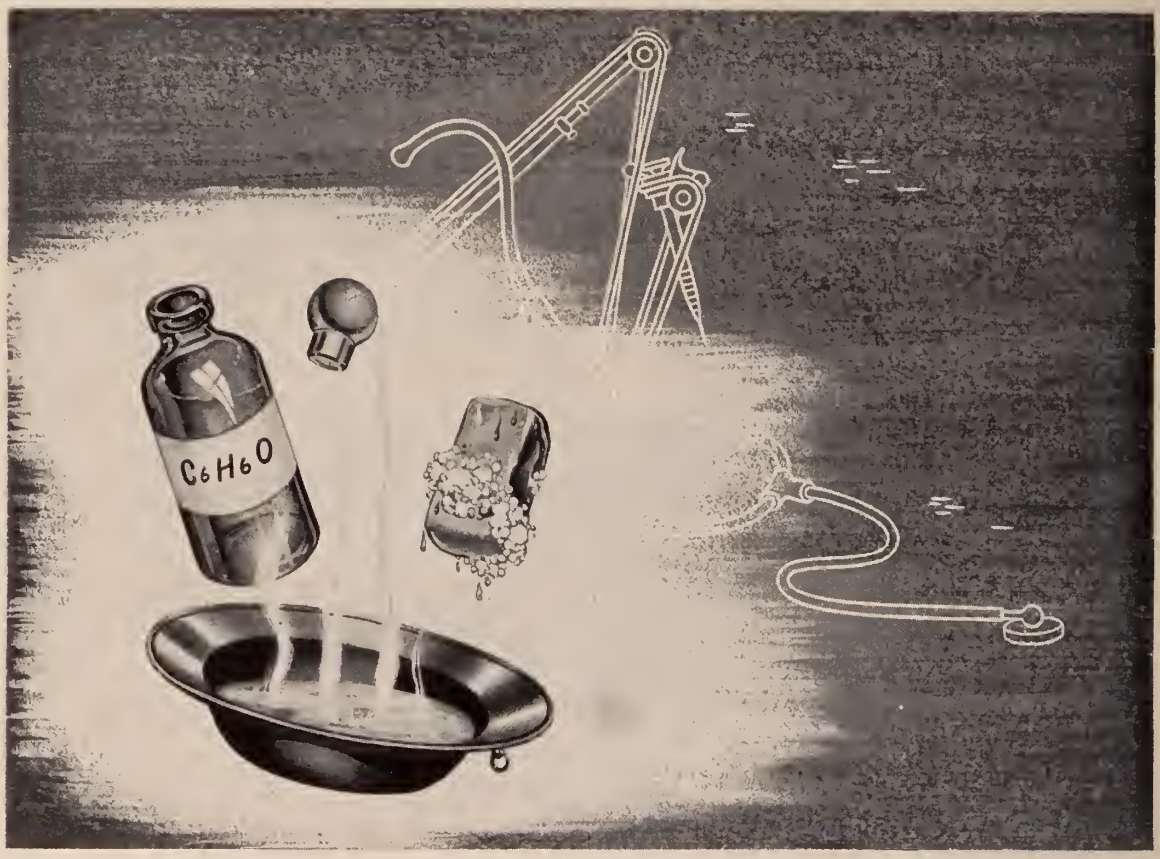

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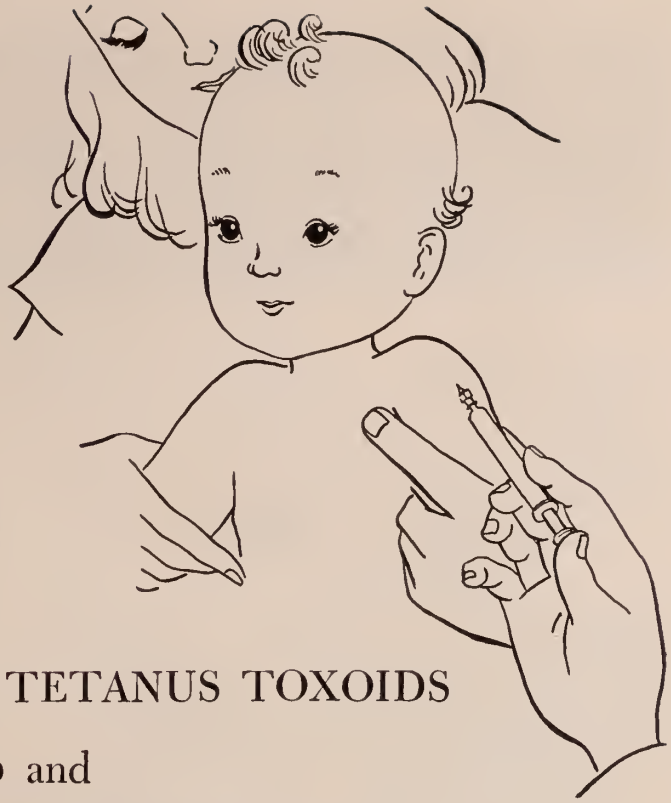

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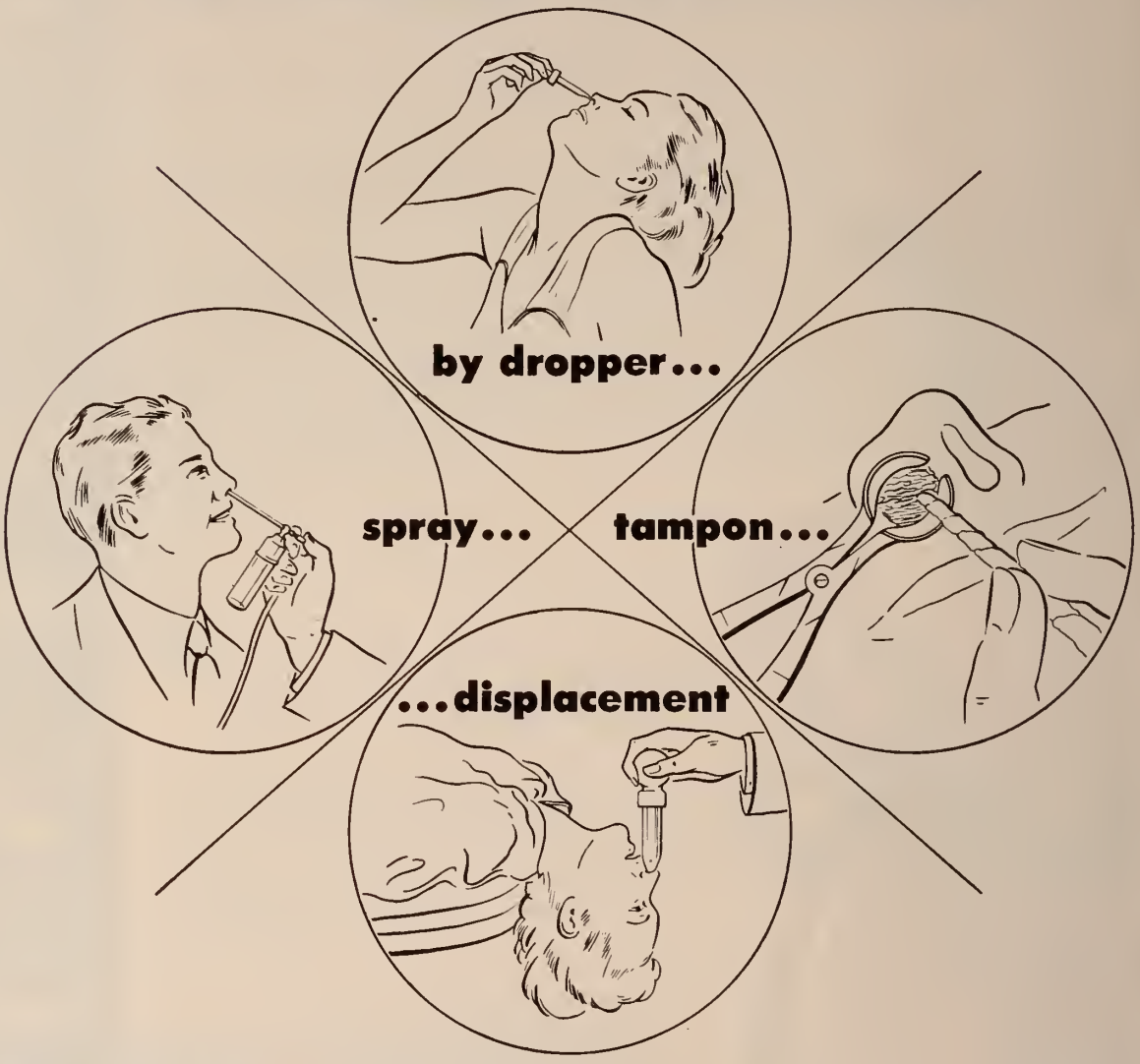

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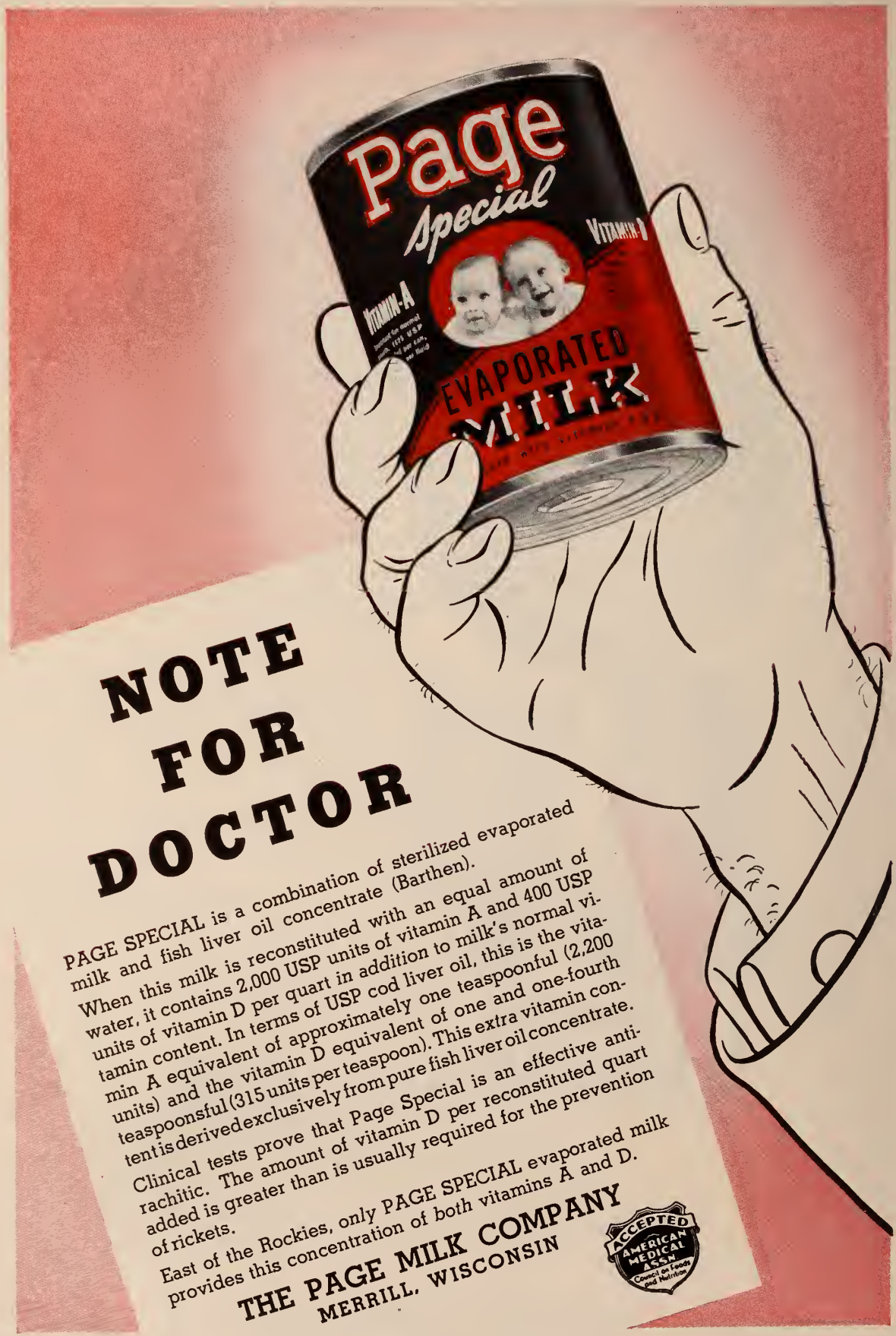

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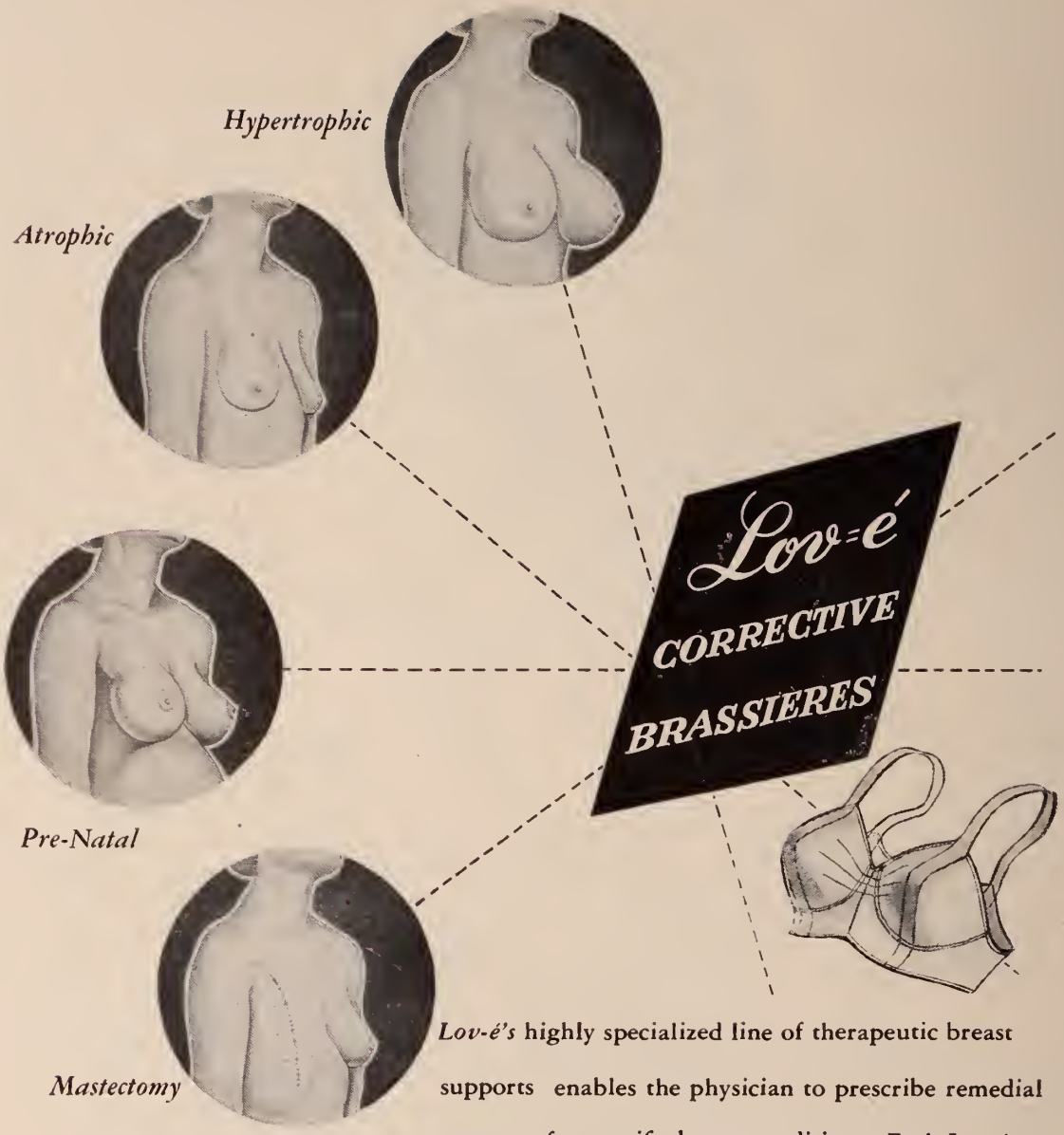

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*Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J. A. M. A. *133*:299, 1947. • Shipley, E. R. and Dodd, M. C.: Clinical Observations on Furacin Soluble Dressing in the Treatment Surface Infections, Surg. Gynec. & Obst. *84*:366, 1947. • Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947.

THE WISCONSIN MEDICAL JOURNAL

VOLUME 47, NO. 11 Copyright, 1948, by The State Medical Society of Wisconsin NOVEMBER, 1948

Some Thoughts of an Incoming President*

By KARL H. DOEGE, M. D.
Marshfield

DURING this year I have had opportunity to think at length about some of the problems presented or confronting us as a Society and as individual practicing physicians, and I wish to bring some of these thoughts to you as they presented themselves to me.

In the last quarter-century we have seen in this country an increase in factionalism, in pressure groups, and in class consciousness. During this time the family doctor, who was a close integral part of his community and was loved by all, has well nigh disappeared. Physicians have become much more highly trained and have had to devote much more of their time to the maintenance of their art and to keeping abreast of the rapidly increasing knowledge of the science of medicine. As a consequence, many physicians are becoming more isolated from the great mass of the people except as they see them professionally. This trend is definitely away from that which is best for the medical profession, as well as for our Society.

America is a mosaic of differing businesses, industries, arts, sciences, and of differing endeavors; and, whether they like it or not, they are all fitted closely together and are all interdependent. This interdependence makes it very important for each group or each type of business or endeavor to render service to every other group. In this manner, all benefit.

Every individual in the medical profession at this time particularly MUST conduct himself with the knowledge that the maintenance of good health and welfare of ALL other groups is his duty and the duty of his profession to society. Every physician must know that this duty does not end at his office door. This obligation includes the financial welfare of the people in each community and the nation at large. It means, as has often been stated, "Bring the advantages of modern medicine to all of the people."

Everything within the powers of the medical profession, individually and collectively, must be done to accomplish this end. We must interest ourselves in every agency that has to do with health or sickness, welfare agencies, social service, prepaid health plans, public health agencies, and the activities of other states to meet this obligation.

In this connection I wish to draw your attention to an interesting plan known as the Maryland Plan, which is a program set up by the State Medical Society of Maryland and operated jointly by public health officers and private physicians. It promises two things—an intensive sanitation and preventive medicine program, with private practitioners assisting part-time, plus medical care on a private basis for those who can't pay for it. It is financed by county funds, state and federal funds. It covers the indigent and very low income groups and will certainly bear watching. The Maryland Plan has not yet found all the answers, but it is a serious attempt to solve a problem that cannot be solved by armchair pronouncements.

Right here I should like to urge that every doctor in Wisconsin should learn at once the fundamentals of the Wisconsin Plan and Wisconsin Physicians Service, known as the Blue Shield Plan, and the difference between a service plan and an indemnity plan. They have been explained many times. If we do not bring the advantages of modern medicine to all of the people, you may be very sure that we will eventually stand on the sidelines and see other agencies take over and do it, and we will find ourselves in the position of day laborers in the health program.

Paul R. Hawley, chief executive officer for the Blue Cross-Blue Shield Commission, recently stated, "The demand for more comprehensive medical care and for an effective means of budgeting its costs has grown within ten years from a whisper to a roar." He stated that voluntary plans must offer as comprehensive a coverage as the public demands, regardless of cost—several kinds of contracts to meet the needs and pocket books of the people, separate fee schedules for each type of contract, uniform coverage for all members of large groups or employers, regardless of their place of residence, and a national service agency to carry out this task.

He pointed out that while every thinking person knows that socialized medicine would be a mistake, this issue will not be decided by wisdom but by the emotions of the people who only know that all they want is good medical care at a price they can afford, and who are not capable of choosing the best way of distribution. He added that it is useless for the medical profession to undertake the education of our people to the dangers of socialized medicine. "Only an immediate expansion and improvement of existent prepayment plans can preserve free medicine," he concluded.

* Presented before the House of Delegates of the State Medical Society of Wisconsin, Milwaukee, October 1948.

In Wisconsin the health of and the cost of medicine to farmers and laborers are of great concern to us. Efforts have been made by farm coperatives to install health plans, and recent legislation has been passed making cooperative hospital and medical care plans possible. It seems obvious that it is too late for organized medicine to do anything with most national labor heads who are demanding nothing short of complete national health insurance. It is not too late, however, for us to convince and demonstrate to our labor unions that we can bring better health service to laborers at lower cost than any state or federal plan can offer.

A recent court decision in a finding for a union ruled that health and welfare clauses could properly be included in labor contracts and used in bargaining. I would like to suggest that an appropriate committee of the State Medical Society of Wisconsin consider, as one of its study projects, health and welfare as applied to union labor, and be in a position to offer unions and employers valuable information and assistance.

Many physicians are inclined to discount the criticisms of the medical profession and probably understandably so, inasmuch as they may consider their personal conduct above reproach. The public understands and admires the advances in medicine, but it is also to be understood that their resentment, whatever its basis, can be in a measure attributed to the misconduct or possibly thoughtless practices of many of us or a few of us.

It is quite obvious that the good will that patients have toward a physician as an individual does not extend to the profession as a whole. Medicine, its problems, its advances, its benefits, have become very popular. Newspapers daily contain articles which are splendid, explaining in lay language many of our diseases and their treatment. The public is vitally interested in having these advances made available to it, particularly in as much as many of the new discoveries have been made in our great universities and medical schools financed by the public's tax dollar.

It is a curious thing that many of us physicians, possibly in an effort to maintain our professional dignity, dislike very much to discuss such mundane problems as fees and the cost of a certain medical service. With but very little exception, everything that we purchase today is offered in a priced package or in a unit of service, with the possible exception of the services of the medical and legal professions. We realize that frequently the patient is not in a position to judge as to whether some of our special expensive services are necessary. However, I do believe that a little salesmanship on the part of the physician, explaining to the patient the result, or the reason why such a special service is necessary, in a great measure will serve to make him feel that his dollar has been well spent.

If our standard of what we consider a fair fee for the middle income group is established, I wonder whether we are as careful to reduce our fees for those patients in the low income group as we are to raise our fees for the high income group. Many wealthy patients are extremely resentful at what they believe to be a gross overcharge for services rendered. Can we justify this on the basis of the free work we do?

Some of us in our metropolitan areas have opportunity to work in free clinics; but should we receive credit for that when we stop and think that as a result of the experience gained there, and the reputation gained for being connected with that free clinic, a practice may become more exclusive and more remunerative? A life insurance salesman may give much valuable information to three or four clients before he finally succeeds in selling his wares to one of them. Practically every successful business, of whatever nature, has as a background to its success the free service it renders.

Or, should we excuse a high fee on the basis of saying that our responsibility is greater? Well, is it? Is our responsibility any greater in caring for the rich than it is for the poor? I don't think so. There is everywhere a happy medium in charges for services rendered. I think the time is here when we should give that very, very serious thought. I do not for a moment contend that fees should not vary. I think variation in fees is justifiable; but there should be some element of reasonable range that should be a matter of public knowledge. The patient should have an opportunity to have an examination for a reasonable fee, and I feel above all things that fees should be discussed early, preferably before services are rendered.

Another source of great resentment by patients is the necessity for having to wait endless hours in the physician's office, whether by appointment or without benefit of appointment. It would seem that with a little study and a little effort at adequate business management in my office or your office that we could greatly minimize the amount of time lost by the patient from his occupation. A doctor is busy; people are waiting for him in his waiting room, and very often he misses the golden opportunity to have that patient give him an adequate history pertinent to his particular complaint. A careless nurse, a rude technician, can undo in one minute all the good the physician has been attempting to accomplish.

I would like to raise another question: Are we at times guilty of using special services, such as x-ray, electrocardiogram, and so on, as an excuse for failure to spend the time to take an adequate history and conduct a good examination? I don't want to depreciate the diagnostic value of these procedures, but wonder whether they occasionally are used too freely.

In previous years the physician enjoyed a highly respected position in the general life of the community. With our extreme busyness and our tendency to specialization, we tend to become less and less a part of the community in which we live. Public health is being left to the Department of Public Health. The Department of Public Health

needs our cooperation and, more than anything else, it needs our leadership. Instead of being asked by the Department of Public Health to cooperate, we rather should be the forerunners, the leaders, stimulating the mind of the public in the needs of those factors concerned in public health.

I wish to draw your attention to the establishment of the Wisconsin Public Health Council. Much of the work of this Council will be on a county or area basis. It is composed of professional groups, such as medical, dental, and nursing groups, official and voluntary health agencies such as the PTA, Chamber of Commerce, or Farm Bureau, and outstanding citizens who can be helpful in meeting health needs. This offers a great opportunity for the profession to be of valuable aid in correcting local health problems.

There is a crying need all over the State of Wisconsin for homes for the aged and feebleminded, and it is a rather sad commentary that much of the urge to build more homes for these people is coming not from physicians as a group but is coming from the Association of County Judges of the State of Wisconsin. Our Committee on Mental Hygiene and Institutional Care has been doing a masterful job in attempting the above. But it can't do it alone; it needs assistance from every individual member of this Society.

And now this brings me to a subject which is uppermost in all our minds. I refer to the stalemate existing between Surgical Care of Milwaukee and the State Medical Society of Wisconsin.

I understand that the special committee, appointed by direction of the American Medical Association to resolve the difficulties between these two organizations, has been unable to arrive at a solution. I am not familiar with all of the background concerned in the development of this stalemate so am not in a position to judge; but in all fairness I would like to leave one thought with you in connection with this problem.

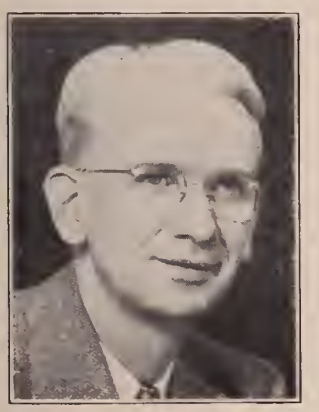
Lifelong friendships have been broken; animosities have been established. How can medicine in Wisconsin present a united front in an effort to do good with such a thorn in its side? If we as doctors, physicians, have as our ideal the purpose of providing our fellow men with modern medical care at a price they can afford to pay, such an ideal should transcend all personal and local considerations; and when it does this problem will be solved.

It is my earnest desire that all committees of our State Society continue to work earnestly and diligently, and that the entire membership of our Society take an intimate interest in the work these committees are attempting to accomplish.

I urge every physician in Wisconsin to realize that he does fill a definite place in society, and that it is his duty to be concerned with the future and welfare of his profession in his county, his state, and his country.

Anesthesiology For Wisconsin

By WILLIAM KREUL, M. D.
Racine



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The secretary of the Wisconsin Society of Anesthesiologists, Doctor Kreul received his medical degree from Marquette University School of Medicine. He holds the office of vice-president of the Southeastern Society of Anesthesiologists and of secretary of the Racine County Medical Society. A fellow of the American College of Anesthesiologists, he is visiting anesthesiologist to St. Mary's and St. Luke's Hospitals and Sunnyrest Sanatorium at Racine.

IN DECEMBER 1947 a group of Wisconsin doctors formed the Wisconsin Society of Anesthesiologists. Physicians limiting their practice and also those devoting part of their time to anesthesia were invited to join. The purpose of the Society is to encourage scientific progress in anesthesiology, to disseminate information in regard to anesthesiology, to make available to more people the benefits to be derived from the services of qualified anesthesiologists, and to develop and further the specialty of anesthesiology for the general elevation of the standards of medical practice. The specialty of anesthesiology has been recognized so recently that perhaps it would be well at this time to mention some of the functions of the anesthesiologists and some of the contributions which they can make to the community and the hospital.

That an anesthesiologist has the ability to produce anesthesia for surgical procedures is presupposed. However he can do much more. In recent times the basic elements of anesthesia have been recognized and enumerated: namely, hypnosis, or induced sleep; analgesia, or the lack of response to painful stimuli; and the relaxation of muscles. Each of these may be accomplished independently of the other, using the same or different agents. It is the duty of the anesthesiologist to provide those elements of this triad which are necessary during any one operative procedure in order to satisfy the needs of the patient

and the surgeon. These needs vary in a host of ways, and it may be said that no two cases are alike. They may actually change during the course of the procedure. Likewise, changes in the manner of accomplishment may be necessary.

Advances in surgery have been many and far-reaching. Hours rather than minutes are consumed in doing intricate life-saving surgical reconstructions. For these there is a need of something more than a "little gas" or the "pouring of ether." So that his attention may be directed exclusively to the difficult work at hand, the surgeon should be relieved of all other concern. To accomplish his work the surgeon is entitled to expect that his patient be quiescent with muscles sufficiently relaxed and at a safe plane of anesthesia. He is entitled to expect that routine and emergency supportive treatment will be instituted at the most opportune time. It is the task of the anesthesiologist to provide these conditions.

In prolonged surgical procedures for the treatment of serious pathologic conditions, the anesthetic procedure should be as carefully planned as the surgical procedure. Then, just as in surgical treatment, a certain amount of improvision must be undertaken as the procedure progresses. For example, an excessive slowing of the heart due to vagal stimulation by the anesthetic agent or the surgical procedure demands a change of agent or the use of a second agent or drug to nullify the undesired effect on the heart. Similarly, when respiratory minute volume is reduced beyond a safe limit according to the agent in use and the patient's condition, changes in the use of the agents must be made in order to increase the depth and/or rate of respiration as indicated. In like manner to await a rapid pulse, a drop in blood pressure, and the peripheral vasoconstriction of shock is not good practice. The factors that contribute to shock must be noted and evaluated as they occur and measures taken to combat them in time to prevent shock. This does not gainsay the fact that shock will occur on occasion in spite of all.

The use of nerve blocking for regional anesthesia has an important place in the armamentarium of the anesthesiologist. Its proper application offers a safer method of analgesia in the poor risk and emergency surgical patients. At this particular time nerve blocking of sympathetic nerves and peripheral nerves in the differential diagnosis of peripheral nerve and vascular disorders is developing rapidly. Since the anesthesiologist is specially trained in nerve blocks of all types, he can be of considerable help to the physician and surgeon in problems requiring nerve block procedures for differential diagnosis. Therapeutically, nerve blocking is finding a place in the treatment of painful conditions of the extremities. The intractable pain of incurable diseases is being controlled in some instances by periodic nerve blocks of various types.

Spinal analgesia formerly consisted mainly of dissolving procaine crystals in cerebrospinal fluid and reinjecting with the dose as the principal variable. Now, several drugs are used in various weights of solution, concentrations, dermatome levels, and positions according to what surgical procedure is to be performed. Some of the dramatic results are true saddle area blocks, one-legged blocks, and hemithoracic blocks. Prolongation of analgesia with greatly reduced total dose has been accomplished recently.

There are numerous situations outside the operating room in which the anesthesiologist can be of real help. Resuscitation is of especial note. Emergency artificial respiration administered manually by means of a rebreathing bag is usually more effective than other methods. From his experience in the operating room the anesthesiologist understands the importance and the means of securing and maintaining a clear adequate airway. Positive pressure breathing is important in the treatment of pulmonary edema. Tracheobronchial toilet shortens the period of morbidity in cases of excessive postoperative secretions. The patient with an overdose of barbiturates or other depressant may also suffer from an excess of pulmonary secretions and from respiratory obstruction. The use of an endotracheal tube to maintain a patent airway and to perform tracheobronchial toilets is indicated.

One can indicate only a few of the reasons for the existence of the medical specialty known as anesthesiology. It is essentially a consulting service. With the expansion of the specialty, more and more doctors will become acquainted with its usefulness.

Many surgeons, physicians, internists, and others recognize that anesthesiology is an integral part of medical practice. In keeping with this fact, the anesthesiologist expects to enjoy the same professional privileges as his colleagues. He does not want to be a hospital employee. He does want to be responsible to the patient and the attending physician and surgeon. When an anesthesiologist enters a community to practice, he expects that his application for hospital staff membership will be considered in the same manner as the internist, the pediatrician, the orthopedist, or other. Supposing that he has provided satisfactory credentials in the light of the usual professional standards and in consequence hospital staff membership granted, the anesthesiologist appreciates any aid in building his practice which he may receive from the established members of the profession in the community.

In the smaller community and hospital if there be a physician devoting some of his time to the practice of anesthesia, he should be encouraged to continue his activities in this field. Also he should be encouraged to identify himself with societies of anesthesiology. Then, as time goes on, that doctor can be an important instrument in bringing to his community the advances in this particular branch of medical practice.

Experiences With Sympathectomy in Peripheral Vascular Disease*

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PERIPHERAL vascular disease presents a major problem of therapy and seems to be a very common complaint, especially in the type of patients seen in large county and government hospitals. The prognosis and the treatment of peripheral vascular disease have changed considerably in the last ten or fifteen years. At the present time our treatment armamentarium is considerably improved, and we are able to offer these patients much more than was their lot years ago, when many of them had nothing to look forward to except eventual amputation after long periods of hospitalization.

Classification of Peripheral Vascular Disease

The following classification of peripheral vascular disease[1] is the one we have been using, although any classification is unsatisfactory because of the tremendous overlap and because many of the subgroups are still not too definitely defined (table 1).

Under functional disease it will be noticed that we have included Raynaud's, pneumatic hammer disease, erythromelalgia, acrocyanosis, trench foot, immersion foot, frostbite, causalgia and causalgic states, and hyperhidrosis. There are considerable organic changes in many of these cases, especially trench foot and immersion foot, but for purposes of classification we have considered them functional, because it is the vasomotor system that requires treatment in both trench foot and immersion foot after the primary local disease has been taken care of. Under the organic classification we have Buerger's disease, aneurysm, arteritis of the periarteritis nodosa type, thrombosis, and embolism. The most important of these are Buerger's disease and arteriosclerosis, although many consider Buerger's disease as being merely a segmental type of arteriosclerosis. The classification which is most useful as regards treatment is that described by Ochsner and DeBakey.[2] They divide peripheral vascular disease into three types (table 2). A classification such as this makes the therapeutic attack much easier. In the pure organic disease, of which arteriosclerosis and Buerger's disease, that are well advanced, are the main types, there is very little treatment that can be given except symptomatic measures. In peripheral vascular disease, however, which has a vasospastic background, be it straight vasospasm or vasospasm with organic disease, many things can be accomplished.

TABLE 1.—*Classification of Peripheral Vascular Disease*

Functional
(a) Raynaud's disease
(b) Pneumatic hammer disease
(c) Erythromelalgia
(d) Acrocyanosis
(e) Trench foot
(f) Immersion foot
(g) Frostbite
(h) Causalgia and causalgic states
(i) Hyperhidrosis
Organic
(a) Buerger's disease
(b) Arteriosclerotic peripheral vascular disease
(c) Aneurysm
(d) Arteritis
(e) Thrombosis
(f) Embolism

TABLE 2.—*Classification of Peripheral Vascular Disease as Regards Treatment*

1. Vasospastic functional disease
2. Vasospastic organic disease
3. Degenerative organic disease

Diagnosis

The general diagnostic procedures that we have been using include a complete physical examination, with eyeground studies, electrocardiograms, phenolsulfonphthalein tests, x-rays of the extremities for calcification, if indicated, and a complete laboratory work-up. A local examination will include palpation of the arteries for evidence of sclerosis, peripheral pulsation, objective evidence of redness or cyanosis, swelling or temperature changes of the extremities, color changes on elevation and dependency, and the

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presence or absence of varicosities. Special examinations include any or all of the following: cold pressor tests, reactive hyperemia, oscillometric readings, skin temperature determination before and after diathermy to the lumbar region, and skin temperature determination before and after sympathetic block. In our clinic the latter three are always used routinely. We have found oscillometric readings to be of great value in determining a rough estimate of the status of the peripheral circulation. Although much can be gained by palpation of the peripheral arteries, pulsations are frequently impossible to get even though circulation is adequate. It is known that anatomically the dorsalis pedis artery pulsation is absent in 4 per cent of normal individuals. The oscillometer removes the guesswork and gives a truer picture of the state of the peripheral vessels. All patients who are being considered for sympathectomy are given paravertebral lumbar sympathetic block with 1 per cent Novocaine. Following, this, the changes in the oscillometric and thermocouple readings are determined. If there is a large element of vasospasm present, susceptible to treatment by sympathectomy, this type of study will reveal it. Figure 1 graphically depicts the response to lumbar block (taken from case 14). We have established

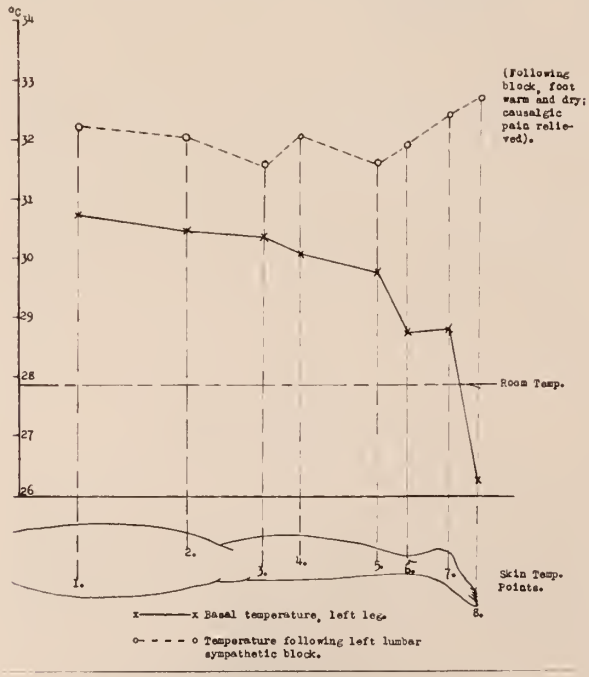

Fig. 1.—Record of temperature in case 14.

eight standard points which we believe should be noted following every sympathetic block and which are important for interpreting the response of the block as an index of the treatment to be given, be it sympathetic lumbar ganglionectomy or other methods of therapy. These factors are shown in table 3. In treating these patients, we have made use of the many procedures that are described in the literature, including Buerger's exercises, rhythmic constriction, diethyl ether given intravenously, histidine and ascorbic acid, and various other drugs that have been advocated. These will not be considered in this paper, since we are more concerned with the reaction to sympathectomy. Ether given intravenously (1,000 cc. of 2.5 per cent ether in saline) has given us several good results and is especially efficacious when some conservative method of treatment must be adhered to because of the physical condition of the patient.

TABLE 3.—*Factors of Importance in Interpreting Response of Diagnostic Sympathetic Block*

1. Increase in skin temperature.
2. The approximation of the skin temperature curve to that of a normal sympathectomized extremity.
3. Paralysis of sudomotor activity.
4. Relief of or improvement in claudication.
5. Relief of causalgic pain.
6. Relief of paresthesia.
7. Improvement in peripheral circulation as determined by oscillometric readings.
8. Relief of rest pain.

Anatomic Physiology of the Sympathetic System

To a very great degree vascular tone is maintained by the sympathetic nerves[2] (fig. 2). This, plus the fact that they are concerned in sudomotor activity, and their role in the complex and not fully understood reflex in causalgia and causalgic-like

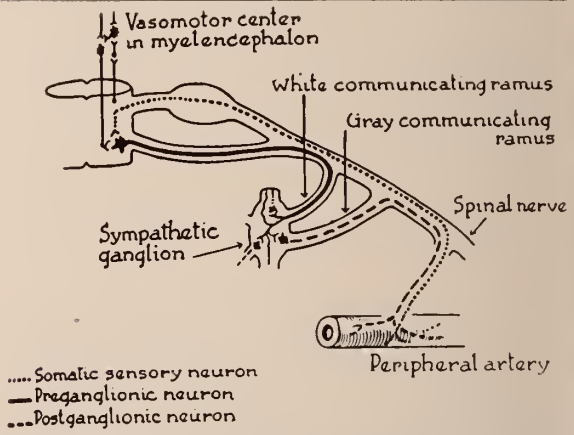

Fig. 2.—Sympathetic vasoconstrictor pathways. Sympathetic control is abolished in sympathectomy.

states, forms the basis of the rationale for the surgical attack on the sympathetic system in peripheral vascular disease. Stimulation of the sympathetic system usually produces constriction of the peripheral arteries. Dale in 1906 showed that the sympathetics carried vasodilator as well as vasoconstrictor fibers.[3] This possibly explains the good results that have been produced in acrocyanosis and erythromelalgia by lumbar sympathectomy. Edgeworth in 1892[4] and Langley[5] in 1903 proved histologically that sensory axons were present in the sympathetic trunk. These sensory neurons are the same as afferent neurons in the somatic system. Perhaps this explains why the pain of causalgia may be relieved by sympathectomy. In the lower

extremities it has been our practice to resect L_2 and L_3, whereas L_1 is resected only when the disease is of sufficient degree to warrant it. The resection of L_1 bilaterally in the male frequently causes loss of power of ejaculation,[6] and viable spermatozoa no longer reach the seminal vesicles.[7] Resection of L_4 is not only unnecessary, but L_4 contains postganglionic fibers, and many men, including Smithwick, White[8] and others, feel that the resection of postganglionic fibers sensitizes the organism to the action of adrenalin to a much greater degree than preganglionic denervation[9-12] and postoperatively there will be a rapid return of vascular spasm. This sensitization to adrenalin has been the cause of a great deal of experimental work[8-14] and Leriche, Pereira, and DeBakey[15] have advocated the resection of the greater and lesser splanchnic nerves together with the lumbar ganglia to decrease somewhat the humoral effects on the rest of the body.

Discussion of Cases and Results of Sympathectomy

It will be noted from table 4 that the conditions we have treated consist of Buerger's disease, residuals of trench foot, causalgia and causalgic state, arteriosclerotic peripheral vascular disease, thrombophlebitis, and chronic indolent ulcers as a residual of old fractures or other injuries. We would like to discuss the results of sympathectomy when applied to these various diseases and what we have found can be expected from the operation and what are its limitations.

TABLE 4.—*Cases and Results of Sympathetic Ganglionectomy*

Disease*	No. of Cases*	Results		
		Excellent	Good	Poor
Buerger's	4 (2 bilateral)			
Case 1		x		
Case 2		x		
Case 3		x		
Case 4				x
Residuals of trench foot (Paresthesia, hyperhidrosis, cold sensitivity)	2			
Case 5		x		
Case 6		x		
Causalgia and causalgic state	3			
Case 7		x		
Case 8			x	
Case 9		x		
Arteriosclerotic Peripheral vascular disease with chronic ulcer and/or claudication and/or paresthesia and/or gangrene	6			
Case 10			x	
Case 11				x
Case 12		x		
Case 13		x		
Case 14			x	
Case 15		x		
Thrombophlebitis	1			
Case 16		x		
Chronic ulcer Residual of old fracture and/or osteomyelitis and/or nonunion	5			
Case 17			x	
Case 18		x		
Case 19		x		
Case 20		x		
Case 21		x		
Total	21	15	4	2

*Since the time this paper was written, ten additional sympathectomies have been performed: one for Raynaud's disease, four for chronic thrombophlebitis, one for causalgia, and four for Buerger's disease (two bilateral). Total: 31 cases and 35 extremities.

Buerger's disease is characterized by its chronicity and the tendency toward periods of exacerbation and remission. It is well known that the disease is accompanied, especially early in the pathologic process, by a considerable amount of vasospasm. The exacerbations are due to renewed acute thromboangiitic processes. The remissions are dependent upon a quiescence of these processes as well as the establishment of new collateral circulation and the canalization of the thrombi that are present in order to re-establish adequate circulation to the extremity. It has been well established that sympathectomy, either chemical or surgical, is an excellent method of treating thrombophlebitis, and this applies also to Buerger's thrombophlebitis and arteritis. Not only does the operation tend to bring about a remission of the disease, but, by relieving the spasm of the vessels, and especially of the collateral vessels, adequate circulation is re-established. Most patients with Buerger's disease suffer with the disease for many years, and are incapacitated to a greater or lesser degree; yet the disease in many never progresses to the point where amputation is required. Most of those who do come to an amputation come to it later in life. Although the operation definitely does not cure the disease or even attack the source of the pathologic process, it may bring about a prolonged remission. It may cause future exacerbations to be less severe and of shorter duration and may push back the disease for many years, so that in younger patients there may be a long period of apparent normalcy, if not complete normalcy, for the rest of their lives. Many patients who would require amputation if given other methods of treatment may have amputation postponed for a sufficient number of years so that they may even live their life span without loss of limb.

We have treated 4 patients (six extremities) with Buerger's disease by sympathectomy. In the first (case 1), a bilateral operation was done. The results on the left foot were excellent in that the foot was warm, the color changes were relieved, the pain was abolished, and tolerance to cold was improved. On the right foot, the postoperative skin temperature curve showed only slight improvement over the preoperative curve, and, although there was immediate relief of claudication, the patient was again hospitalized nine months later because of return of this latter symptom. The right side was re-explored, and it was found that L_2 had not been removed at the first operation. Following removal of L_2, an excellent result was obtained with complete symptomatic relief. In 2 other cases (cases 2 and 3) (five extremities) excellent results were obtained, the feet being warm, dry and pink, and with complete relief of claudication and rest pain. The results in the

remaining case (case 4) were poor. This outcome, however, was expected inasmuch as the patient was a 58 year old man with far advanced Buerger's disease and gave no evidence of improvement after sympathetic block. However, the patient had a chronic infection of his left great toe and was in constant pain requiring the use of opiates. The operation was tried as a heroic last resort measure. The leg did get slightly warmer, and there was sufficient relief of pain so he required opiate sedation only occasionally at night. The patient, however, refused to give up smoking. The infection of the toe failed to heal and finally progressed to the point where amputation was resorted to.

The residuals of the three closely allied conditions, trench foot, immersion foot, and frostbite, can usually be grouped into complaints caused by sympathetic over-activity, nerve injury with resultant hypesthesia, paresthesia, or actual pain, and combinations of these. Shumacker[16] found that a sensitization phenomena results frequently as a residual of any of the three, frostbite, trench foot, or immersion foot, but true Raynaud's phenomena developed more frequently following frostbite than the other two. On the other hand, sensory changes were more apparent in immersion foot, while pain on weight bearing was caused most frequently by trench foot. Frequently, these patients can be greatly helped by conservative treatment, such as massage, exercise, foot soaks, formalin iontophoresis, and orthopedic appliances for painful weight bearing. However, if the residuals are sufficiently incapacitating, especially if they are caused by sympathetic hyperactivity, sympathectomy is indicated and usually gives excellent results. Excessive hyperhidrosis with its resultant maceration and chronic infection about the toes can be cured in virtually 100 per cent of the cases. The Raynaud's phenomenon which is observed so frequently following frostbite is amenable to this surgical treatment. Paresthesia and hypesthesia are frequently helped by sympathectomy. However, the deep pain on weight bearing which is usually found in the heel and sometimes in the ball of the foot and is a not uncommon residual of trench foot is frequently not benefited at all by sympathectomy.[16] Thus it is seen that excellent results can be anticipated in special cases of residuals of trench foot, immersion foot, and frostbite. Many of these patients have been seen in the peripheral vascular clinic, and most of them have been treated by the various conservative methods mentioned above. Two patients (cases 5 and 6) complained chiefly of paresthesia, hyperhidrosis, and cold sensitivity, and these 2 patients were operated on, with complete relief of symptoms.

We have performed sympathectomies on 3 patients for causalgia or causalgic-like states. One of these (case 7) was a true causalgia, which developed as a residual of an injury to the left sciatic nerve caused by a gunshot wound in 1944. The patient's foot was so sensitive that he was unable to walk on it, and the slightest touch to the bottom of the foot brought on agonizing pain. In addition, there was such extreme hyperhidrosis that the foot was constantly dripping perspiration. The preoperative sympathetic block indicated that we could expect complete relief by operation, and this was accomplished. The second case (case 9) was a 43 year old white male, who complained of paresthesias and pain over the first and second toes, right, and also at the lateral aspect of the right foot. This patient also received complete relief from surgical treatment. The third patient (case 8) was a 47 year old white male, who complained of a burning pain of the sole of the right foot, hyperhidrosis, and also a deep burning pain of his right heel. The cause was undetermined. A preoperative sympathetic block gave a good response, and he obtained relief from his hyperhidrosis and burning pain of the sole of the foot postoperatively. However, this patient was seen about one month after discharge and still complained of a slight residual deep pain of his right heel on walking. Although no history of freezing or trench foot was obtainable from this patient, it is interesting to note that this is the same type of pain referred to above that Shumacker has found is a not uncommon residual of trench foot and frequently is not relieved by sympathectomy.

We have treated 6 patients with arteriosclerotic peripheral vascular disease with sympathectomy. In 3 there were excellent results: One was a patient (case 12) with an ischemic ulcer on the inner surface of the distal surface of his left leg, present for three and a half years. Repeated and prolonged conservative therapy at this hospital produced no results. Work-up indicated sympathectomy, and following operation the ulcer healed completely within three weeks. The second patient (case 13) had a gangrenous ulcer of the right heel of one and a half months' duration. Following sympathectomy, the superficial gangrenous tissue sloughed and the ulcer promptly healed. The patient in the remaining case in which an "excellent" result was obtained (case 15) was a 72 year old white male who complained of severe claudication. It could not be established whether this was due entirely to arterial causes inasmuch as he also had evidence of chronic thrombophlebitis, and there was a stasis dermatitis of both lower legs. However, paravertebral block indicated that the patient would be helped by sympathectomy. Following surgical treatment the foot was warmer than the control side, the color was improved, the dorsalis pedis pulsation, which was absent prior to operation, was present, and the patient's claudication was improved.

The results in 2 of the cases of arteriosclerotic peripheral vascular disease were classified as "good." One of these (case 10), a 73 year old white male, had a questionable old thrombophlebitis in addition to his arteriosclerosis. He complained of claudication, rest pain, and sensitivity to cold. Following operation his rest pain, claudication, and cold sensitivity were abolished. Thermocouple and oscillometric readings taken postoperatively showed a good re-

sponse to surgery. However, this patient complained of a "different type" of pain postoperatively. He stated that his leg ached constantly, but it was not severe enough to prevent him from walking and was relieved by placebo hypodermics. This was perhaps a bad selection inasmuch as the patient was 73 years of age and showed evidence of cerebral as well as peripheral arteriosclerotic vascular disease. The patient in the other case with a "good" result (case 14) was a 59 year old white male, who complained of numbness of the lateral three toes, coldness and paresthesia of the left foot, and claudication on walking. He obtained relief from all these symptoms following a sympathetic block, and the immediate result postoperatively was excellent. His foot was warm, dry, and pink, the sensation of the toes was normal, and he had relief of claudication. About four months later the patient again complained of pain in the foot, although now his pain involved the transverse metatarsal arch. We thought that this was unrelated to his initial complaint, and the patient was given orthopedic correction, with much improvement. However, he still had some residual pain in the ball of the foot, and this was never relieved.

In 1 case of arteriosclerotic peripheral vascular disease, the result of sympathectomy was "poor." This patient (case 11) was a 54 year old white male, who had been seen as an outpatient in the peripheral vascular clinic, complaining of arteriosclerotic peripheral vascular disease with severe claudication. A sympathetic block was done, with no results, and surgical treatment was not recommended. Three months later the patient was admitted to the hospital with an arteriosclerotic gangrene of the right heel, and a few days after admission patchy, superficial areas of gangrene developed over the right knee. An idea of the status of this patient's peripheral vascular system can be obtained by the fact that an attempted arteriogram was unsuccessful because the femoral artery was so sclerotic it could not be located for injection of the contrast medium. A sympathectomy was done in the hope of improving healing following the amputation, which was inevitable. Following the sympathectomy there was immediate and rapid progression of the gangrenous process. Both DeTakats[17] and Atlas[16] among others feel that when vascular changes have reached the point where there is very little vasospasm in the picture and sympathetic block produces no response, or even a paradoxic response, a sympathectomy may hasten the progression of the disease and even precipitate gangrene. From our one experience we are inclined to agree with this observation.

In 1 case of thrombophlebitis (case 16) the patient was treated by sympathectomy. This was a 50 year old white female, who had her disease for a period of one and one-half months prior to the time of operation. The patient had a history of a typical attack of severe thrombophlebitis with pain and swelling of the leg, accompanied by chills and fever. There was massive edema extending up to the inguinal ligament and tender inguinal adenopathy. Venograms were made and showed obstruction of the deep veins of the right leg and pelvis. The patient was first treated on the medical service with anticoagulants for a period of one month. Repeated sympathetic blocks were done by the surgical service, with relief of pain and diminished cyanosis and swelling following each block. Because of the recurrence of symptoms and the extent of the edema, sympathectomy was performed. The results following surgical treatment were excellent, and the swelling subsided completely. She was discharged three weeks following operation, with no residuals whatsoever from her thrombophlebitis.

We have treated 5 patients with chronic ulcer of the leg which were residuals of an old fracture and/or an old osteomyelitis, and in 1 case residual of an old fracture with nonunion. Excellent results were obtained in 4 of these cases, and in the fifth the result was "good." One patient had a chronic ulcer of his left ankle for fifteen years (case 18). This was residual to an old fracture and chronic osteomyelitis which had subsequently healed. The ulcer failed to heal because of excessive scar tissue and vascular insufficiency. Following sympathectomy the ulcer healed within three weeks with no local treatment whatsoever to the ulcer area. This is typical of the response we have been getting in such cases. A fifteen year period of duration of the lesion is exceptional. The average duration of the ulcers treated by sympathectomy was two and a half years.

Two of our patients were referred to the peripheral vascular service by the plastic service in order to have a sympathectomy performed in anticipation of a skin graft to the ulcer area. The first of these 2 patients (case 19) had a chronic recurring ulcer of the right ankle as a residual of an old fracture and osteomyelitis of the ankle. There was marked ischemia due to scar tissue and vasospasm. The ulcer healed within one week following the operation, and it was unnecessary to perform the anticipated skin graft. The patient was discharged with instructions that the ulcer may again break down on activity and if this occurs to return for plastic treatment. He returned to his former occupation and the lesion has remained well healed. The other patient referred by the plastic department (case 17) was a 54 year old male who had a chronic draining ulcer of the lower third of his right leg of two years' duration, following an old fracture of the tibia. The patient had a nonunion of the tibia and had had three previous attempted skin grafts on both the orthopedic and the plastic surgical services, one of these a full thickness graft and two split thickness grafts—all without success. The work-up indicated that a good response could be expected from a sympathectomy, and this was achieved. The vascularity of the extremity was markedly improved, although the ulcer in this case did not heal spontaneously. The patient was trans-

ferred back to the plastic surgical service for further skin graft, and a pedicle flap transplant was successfully accomplished.

Conclusions

1. Peripheral vascular disease produces a tremendous economic waste in all large general hospitals because of the chronicity and resistance to treatment of this disease.

2. For purposes of treatment, peripheral vascular disease is best divided into: (a) vasospastic functional disease; (b) vasospastic organic diesase; and (c) degenerative organic disease.

3. The best diagnostic procedure from the standpoint of indicated treatment is procaine block of the involved sympathetics, and then noting of the eight factors mentioned in this paper.

4. Buerger's disease, causalgia, Raynaud's disease, and residuals of trench foot and allied conditions can be helped tremendously by sympathectomy, and the results are achieved much more rapidly than by more conservative measures.

5. Arteriosclerotic disease of the extremities that has not progressed too far and still has an element of vasospasm present may be helped by sympathectomy.

6. Sympathectomy, in organic arterial disease without vasospasm, is inadvisable and may hasten the progression of the disease.

7. Chronic indolent ulcers, due to ischemia from old gunshot wounds or old osteomyelitis of the extremities, may frequently be helped by sympathectomy.

8. In certain cases chronic thrombophlebitis may yield to sympathectomy.

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PUBLIC HEALTH CONFERENCE TO BE HELD DECEMBER 20 AND 21

Everyone interested in public health is invited to attend the public health conference set for December 20 and 21 at the University of Wisconsin Memorial Union, Madison, to be sponsored by the Wisconsin Public Health Council, the Wisconsin Association for Public Health, the University of Wisconsin, and the Wisconsin State Board of Health. All full time public health workers are asked to attend the formal organization of the Wisconsin Association for Public Health at the Memorial Union at 8 o'clock Monday evening.

Nationally known authorities on public health and panels of experts will discuss various phases of the subject, and the audience will participate in the discussion.

The Treatment of Mercury Poisoning With B.A.L. and Peritoneal Irrigation

By B. J. LONGLEY, M. D.
Madison

B. J. LONGLEY

A 1942 graduate of the University of Wisconsin Medical School, Doctor Longley interned at the University hospital of the University of Pennsylvania School of Medicine. After a residency in general surgery at the State of Wisconsin General Hospital, he accepted his present position as assistant coordinator of the Tumor Clinic of the State of Wisconsin General Hospital.

RENAL failure, with the resulting uremia, usually has a poor prognosis unless the renal damage is reversible and can be corrected sufficiently early. During recent years, it has been recognized that certain types of renal damage hitherto considered irreversible might be amenable to treatment provided the damaged kidneys have enough time to recover.

The removal of the waste products from the blood can be performed by any permeable membrane across which the waste products may diffuse. Such membranes are found in the peritoneum, in the mucous membrane of the gastrointestinal tract, and in the cellophane tube of the so-called "artificial kidney."

Seligman[1] tried irrigating a loop of the gastrointestinal tract and found this to be unsatisfactory. Kolff[2] has used the "artificial kidney" and found it satisfactory, but such apparatus is expensive and is not generally available. Peritoneal irrigation appears to be the most practical and effective method for the removal of nitrogenous waste products from the blood.

Frank[3] repopularized this method in 1946, when he listed renal damage from the following causes as being reversible: sulfonamide poisoning, heavy metal poisoning, transfusion reactions, trauma and reflex, toxemia of pregnancy, and acute nephritis. The inclusion of heavy metal poisoning in this group is open to question, since it is obvious that not all patients poisoned by heavy metals have reversible renal damage. However, the only way to determine whether the damage is reversible is to give the patient all possible support and thus afford time for recovery of the kidney.

Peritoneal irrigation was selected for the symptomatic treatment of a patient with mercuric chloride poisoning, who was admitted to the State of Wisconsin General Hospital on Dec. 27, 1946.

This 43 year old white male cheesemaker had, on the previous day, taken 10 tablets used to preserve milk samples for butterfat testing. It was not possible to determine the exact composition of these tablets, but the active ingredient was mercuric chloride. Cream and eggs administered as an emetic elicited vomiting ten minutes after the tablets were taken. Castor oil, together with more milk and eggs, was given later in the day, during which time he vomited once and had ten diarrheal stools. On the day of admission he passed several tarry stools. There had been intermittent colicky abdominal pain since taking the poison. The remainder of the history was not relevant.

Physical examination revealed a somewhat drowsy, well developed, and well nourished white male. The blood pressure was 140/80, the pulse rate was 104, and the heart was not enlarged. There was generalized abdominal tenderness, most marked in the epigastrium. No other abnormalities were revealed by the examination. Medical treatment consisted of the administration of B.A.L. (British Anti-Lewisite*) and forcing fluids, orally and parenterally.

When the regimen of B.A.L. and forcing fluids appeared to fail, peritoneal irrigation was undertaken. To accomplish this a catheter was placed in the left upper quadrant of the peritoneal cavity, just anterior to the gastric fundus, and a sump pump was placed in the pelvis, local anesthesic being used.

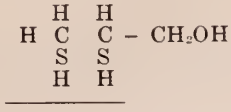
Tyrode's solution (table 1) was run into the catheter and removed via the pump, which was con-

TABLE 1.—*The Composition of Tyrode's Solution*

Sodium chloride	8.00 gm./liter
Potassium chloride	.20
Calcium chloride	.10
Magnesium chloride	.10
Sodium acid phosphate	.05
Sodium bicarbonate	1.00
Dextrose	1.50
Sodium penicillin	5000 units/liter
Sodium sulfadiazine	12 mgm./liter
Sodium heparin	.25 – .50 mgm./liter

*Lewisite is an arsenical gas of the irritant type, similar to mustard gas, which was developed during World War I. In anticipation that Lewisite was to be used in World War II, an antidote, B.A.L., was developed. Subsequently it was found that this compound was of benefit in all types of heavy metal poisoning. Chemically, B.A.L. is 2,3 dimercaptopropanol.

B.A.L.



nected to a trap and then to a water-suction pump. The rate of flow was slow—about 1½ liters per hour.

The patient lived for fourteen days after taking the bichloride of mercury and ten days after the peritoneal irrigation was started. At autopsy, the pertinent findings were as follows: There was considerable pitting edema of the lower extremities, the sacral area, and the dorsa of the hands. There was 500 cc. of clear fluid in the left pleural and peritoneal cavities. The peritoneal surfaces were smooth and glistening, except for areas of the omentum and small bowel which had been adjacent to the sump pump. These areas showed an acute fibrinous inflammatory reaction. On opening the stomach, an ulcerated area on the lesser curvature was noted just below the esophageal hiatus. There were congestion and acute inflammatory changes in the surrounding area. There was considerable blood-stained mucus in the jejunum. In the wall of the jejunum and the ileum there were multiple areas of infarction about 1 cm. in diameter. The spleen was congested, and in the sinusoids there were many macrophages filled with hemosiderin. The liver weighed 1,890 Gm. and the Kupffer cells contained considerable blood pigment. The right kidney weighed 170 Gm. and the left kidney 220 Gm. There was necrosis of the cells in both the collecting and the convoluted tubules. Many tubules were plugged with casts and necrotic debris. The interstitial tissue was infiltrated with polymorphonuclear leukocytes and mononuclear phagocytes. There was a hemorrhagic inflammatory process in the pelvis of each kidney. There was an old infarct in the anterior wall of the left ventricle. Macrophages loaded with pigment were present in the alveoli of the lung.

Observations on the Clinical Course

The effect of B.A.L. and peritoneal irrigation upon the nonprotein nitrogen of the patient is shown in chart 1. The nonprotein nitrogen on admission was about 85, rising to a maximum of 125 on Dec. 30, 1946. The next determination was on Dec. 31, 1946, after four hours of peritoneal irrigation. The maximum reduction of nonprotein nitrogen was obtained on Jan. 8, 1947, when a low of 63 was reached. It rose to 72 on the day of the patient's death. The variation in the nonprotein nitrogen value was

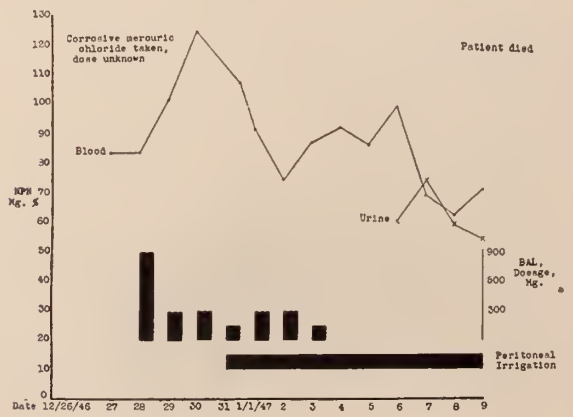


Chart 1.—The effect of B. A. L. and peritoneal irrigation on the nonprotein nitrogen content of a patient suffering from mercury poisoning.

o—o Nonprotein nitrogen in the blood
x—x Nonprotein nitrogen in the urine

caused by a variation in the rate of flow of the irrigating fluid, which was reduced each time pulmonary edema developed in the patient. This reduction in rate of flow may or may not have been necessary; however, in view of the experimental nature of peritoneal irrigation, it was considered best to decrease the rate of flow, in addition to other methods of treatment during the acute phase of pulmonary edema.

The urinary nonprotein nitrogen has been plotted. It will be noted that it is of about the same value as that of the blood. This would favor the interpretation that the urine obtained was a glomerular filtrate without concentration in the renal tubules.

One must not be misled and believe that the fall in the nonprotein nitrogen was due to B.A.L. That the fall in the nonprotein nitrogen could not be due to B.A.L. will be obvious later in the discussion.

The relationship of the rate of flow of the peritoneal irrigation to the nonprotein nitrogen clearance in the irrigation fluid is shown in chart 2. It will be seen that for each 20 liters of solution used, about 17 were recovered. Part of this discrepancy is an error, since some of the fluid in each carboy was wasted in starting the siphon system. However,

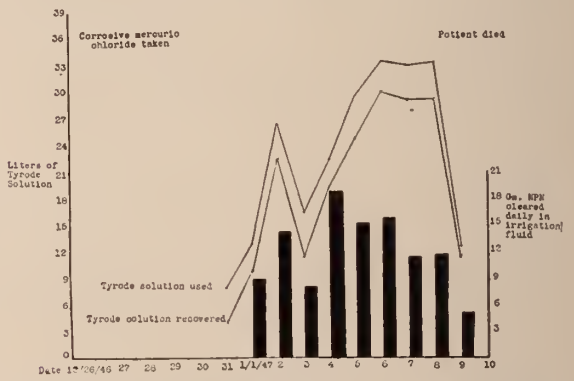


Chart 2.—The relation of rate of flow to nonprotein nitrogen clearance by peritoneal irrigation in a patient suffering from mercury poisoning.

o—o Liters of Tyrode's solution used per day
x—x Liters of Tyrode's solution recovered per day

there may have been some absorption, the extent of which cannot be determined. The rate of flow, as previously stated, was slowed when pulmonary edema developed. Between 5 and 20 Gm. of nonprotein nitrogen were cleared per day in the irrigation fluid. The efficiency of clearance was highest on the first day and decreased thereafter, but was still adequate to lower the nonprotein nitrogen to 63 mg. per hundred cubic centimeters on Jan. 8, 1947. This decrease in efficiency is to be expected when one considers that the peritoneal cavity will wall off a drain, forming a fibrin-walled sinus, in three to five days. Doubtless, the heparin which was added to the Tyrode solution reduced fibrin formation to a minimum.

The relation of the patient's intake and the output to the development of edema is given in chart 3. An additional intake, not represented here, is the absorption which took place from the irrigation fluid. Fluids, including blood, were forced until the onset of pulmonary edema. After the first episode

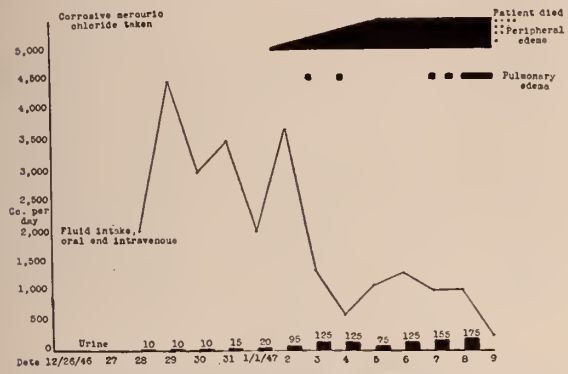


Chart 3.—The relation of fluid intake and output to the development of peripheral and pulmonary edema in a patient suffering from mercury poisoning.

of pulmonary edema, 10 per cent glucose solution was given intravenously each day, in the face of increasing peripheral edema and a blood pressure which rose from 140/80 to 230/108. This was obviously courting further pulmonary edema, but the calculated risk was undertaken deliberately, since the 10 per cent glucose solution was considered the best available diuretic. The maximum urinary output was 175 cc. per day, which was obtained the day before the patient's death. The urine was visibly bloody, contained 2 to 6 Gm. per cent of protein and nonprotein nitrogen in a concentration about equal to that in the blood. Obviously, there was no tubular function. Other points deserving mention are acidosis, peritoneal irritation, peritoneal infection, anemia, diarrhea, and plasma proteins. The patient's alkali reserve varied between 24 and 38 volumes per cent. He was given some sixth molar sodium lactate intravenously, but it was considered that a "wholehearted" attempt to raise the alkali reserve was unnecessary and undesirable. The relation of the acidosis to the patient's death is a matter for speculation. Six to twelve hours after peritoneal irrigation was started, there was some vomiting, which was treated with Wangensteen suction. Thereafter these symptoms subsided and fluids were taken per os. At no time was it possible to culture organisms from the irrigation fluid. Penicillin placed in the Tyrode solution and administered intramuscularly was considered helpful in avoiding peritonitis. The patient's hemoglobin was 16.9 Gm. on admission. This fell to 9.4 Gm. on Dec. 31, 1946. Thereafter the patient received a total of 2,000 cc. of blood. Much of the blood loss was presumably by way of the gastrointestinal tract, since there was a diarrhea with from five to fifteen bloody or tarry stools per day. The plasma proteins were reported to be 7.0 Gm. In spite of this figure, the patient received plasma in hope of decreasing the edema. Additional treatment included vitamins, aminophyllin, and digoxin.

The ultimate cause of death was in all probability pulmonary edema, which was very extensive during the last day of the patient's life. In view of the experience of others, and in retrospect, one wonders if further limitation of fluid might not have been desirable.

Analysis of the tissues for mercury, done by Dr. Frank Kozelka, using his dithizone method,[4] gave the results listed in table 2. It is apparent that much of the mercury was stored in the liver, spleen, and kidney and that the B.A.L. had not been effective in its mobilization. The concentration of mercury in the peritoneal irrigation fluid was .007 mg. per hundred cubic centimeters. Therefore, appreciable quantities of mercury were not removed from the body by peritoneal irrigation.

TABLE 2.—*The Concentration of Mercury in the Tissues of a Patient Dying From Mercury Poisoning*

Tissue	*Mg. Mercury/100 Gm. Tissue*
Heart	0.502
Liver	3.667
Lung	0.336
Kidney	1.250
Spleen	3.787
Blood	0.111 *
Peritoneal irrigation fluid	0.007 *

*Antemortem determinations.

Summary

Peritoneal irrigation was undertaken in the symptomatic treatment of a case of mercuric chloride poisoning. The nonprotein nitrogen of the blood was effectively lowered. Peritonitis did not develop even though the irrigation was continued for ten days. Renal function did not return during this period, and at autopsy there was no evidence of regeneration of the damaged tubules.

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4. Kozelka, F. L.: The determination of mercury in biological material, Anal. Chem. 19:494–496, 1947.

The author wishes to acknowledge his indebtedness to Dr. J. L. Sims for supplying the B.A.L.; to Dr. M. A. Angevine for the postmortem studies; and to Dr. F. L. Kozelka for the mercury determinations.

Bronchogenic Carcinoma

The Cytologic Diagnosis From Bronchial Aspirations

By LAWRENCE L. SWAN, M. D.*

New Orleans

L. L. SWAN

Doctor Swan, pathologist at the United States Marine Hospital in New Orleans, last year served as assistant professor of clinical pathology at the University of Wisconsin Medical School. A graduate of the University of Illinois College of Medicine, he is a diplomate of the American Board of Clinical Pathology and Anatomical Pathology. In 1946-1947 he was pathologist for the Chest Tumor Registry of the American Registries of Pathology.

Introduction

DR. JAMES WARING[1] recently stated that he is pessimistic about the prognosis of cancer of the lung, for at this date the five year cures after surgical treatment are no more than 5 per cent. This figure should be materially improved by educating the public to report to their physicians promptly when the first symptoms occur and by improving the acuity of our present diagnostic methods; the latter is the concern of this paper. There is urgent need for development of new methods for the early detection of primary pulmonary neoplasms.

History

The cytologic diagnosis of bronchogenic carcinoma is not a new method of cancer detection and has been recently revived by Dr. George N. Papanicolaou. As early as 1860 the presence of fragments of tumor tissue in sputum in cases of carcinoma of the lung was reported.[2] It was not until 1935, when Dudgeon and Wrigley[3] published their series, that present day methods were employed, and the wet smears were immediately fixed in Schaudinn's solution. In a series of 58 proved cases of pulmonary carcinoma, it was possible to establish a positive diagnosis in 68 per cent from the examination of the sputum, and in the majority of instances the histologic type of growth could be demonstrated. The most complete study to date is that of Wandall,[4] who in 1944 reported that in 100 cases of proved lung carcinoma, 84 per cent of the sputums contained malignant cells. Bronchoscopic examination was performed in 82 of these cases, and endoscopic biopsy was reported positive in 55 per cent. The cytologic diagnosis in this same series was positive for malignant cells in 82 per cent of the cases. In a total of 193 sputums, false positive diagnoses were made six times. In 1946 Herbut and Clerf[5] examined the bronchial aspirates from a series of 30 proved cases and reported 73 per cent of the smears to contain malignant cells. From the same series endoscopic biopsy was reported positive in 36 per cent, and in 7 cases the biopsy was reported as negative. Woolner and McDonald[6] concluded in 1947 that a positive result may be expected in at least 80 per cent of the cases.

Material and Method

In our experience, as well as others,[5] the most suitable material for the detection of bronchogenic carcinoma is bronchial aspirate: however, the ease in obtaining sputum makes this latter material the method of choice in more routine studies. The bronchial secretions are obtained from the trap, smeared on a clean slide, and immediately plunged into a bottle containing a solution of ethyl ether and 95 per cent ethyl alcohol to prevent air drying. Many consider this step of proper and adequate fixation as the key to successful slide preparation. If the bronchial secretions are scanty, the trap is washed with at least 10 cc. of alcohol, and the washings are then sent to the laboratory for centrifugation and smearing. Sputum is best obtained by instructing the patient to expectorate into a small bottle half filled with 70 per cent ethyl alcohol (isopropyl may be used). The immediate alcohol fixation is a highly important step, for the rich bacterial flora present in the mouth quickly destroys significant cells in unfixed material. Specimens thus prepared may be shipped in the mail or allowed to stand several days without serious harm to the cells. There is usually precipitation of mucus by the alcohol, and this material is crushed on the slide and smeared. The slides are stained according to the technic evolved by Papanicolaou.[7] Routine hematoxylin and eosin[6] and Wright's[8] stain have also been used with success.

The microscopist must be highly conversant with the cellular components of bronchial secretions and sputum, and considerable skill is essential to the proper interpretation of the cells present in the smears. The cytologic diagnosis of cancer is not for the casual or poorly trained individual, and the irresponsible observer may well put a good tool into disrepute. One must be constantly on the alert for variations of the ciliated epithelial lining cell of the bronchus. If the cytoplasm, terminal bar, and cilia are intact, there is naturally no difficulty in identification; however, there are, upon rare occasions, factors which cause the bare nuclei to be

*With the technical assistance of Miss Norma Freitag, B.S., Madison.

found in small clumps. At times it is only with the most meticulous scrutiny that these small pyknotic nuclei can be differentiated from the small round cell or spindle cell types of bronchogenic carcinoma. One must proceed with considerable caution when squamous cells are present, especially in bronchial secretions, for most false positives in other series have been attributed to squamous cell metaplasia of the bronchial epithelium in bronchiectasis. Others have reported difficulty in recognizing variations in the alveolar phagocytes, but this has not proved to be true in our experience. In 1 case of malignant pulmonary adenomatosis (alveolar cell carcinoma) a correct diagnosis was made by sputum and bronchial smear. The pertinent findings were the unusually numerous alveolar phagocytes lacking engulfed material and occasional monster phagocytes with as many as seven nuclei. Rarely were manifest malignant changes seen.

Interpretation of Reports

In cases in which malignant cells are present it is advisable in bronchial aspirations and especially sputums to merely report "malignant cells present." Although on rare occasions one can determine the type of bronchogenic neoplasm from the smear, it must be kept in mind that in the great majority of cases the site or type of malignancy is not apparent from the slide examined. For instance, if malignant cells are found in sputum, these cells may actually arise in the mouth, the accessory nasal sinuses, the upper respiratory tract, esophagus, or pharynx. Similarly, in bronchial smears, it is not cytologically apparent whether or not the tumor is primary or secondary. In cases in which only one or two cells strongly indicative of malignancy are found or in which unidentified atypical cells are present, "suspicious cells" or "doubtful carcinoma" is reported. A doubtful report should, therefore, be tantamount to a request for more smears, and efforts should be redoubled to locate the source of the signs and symptoms. A negative report does not mean that carcinoma is not present. This should be interpreted as being indicative of no malignant cells being seen in the particular slide being examined. Additional material should be examined, and the number of positive diagnoses is directly proportional to the number of smears examined.

Present Study

This preliminary report is based on 50 consecutive bronchial aspirations in cases in which there was a clinical impression of pulmonary neoplasm. There were 11 cases in which malignant cells were reported in the bronchial smears. Six cases were reported as doubtful, and 33 were reported as negative.

In those cases reported as positive 7 cases were proved positive by tissue (see table 1). In 2 cases the tumor masses were visualized by bronchoscope, and in the remaining 2 cases the bronchogram was

TABLE 1.—*Positive Diagnoses*

	No.	Per Cent	
Proved by biopsy	6	55	64%
Proved by autopsy	1	9	
Number seen by bronchoscope	2	18	
Bronchogram	2	18	
Total	11	99	

definitely positive and the patient's condition was such that further studies were inadvisable. A breakdown of the 7 cases in which tissue was available (see table 2) reveals that the chest roentgenogram reported a tumor present in 4 cases. Two cases showed suspicious lesions, and 1 case was read as negative for tumor.

TABLE 2.—*Analysis of the 7 Cases Proved Positive by Tissue*

Number	X-ray	Bronchoscopy	Bronchogram
1	+	+	+
2	±	+	0
4	+	+	0
7	±	—	±
12	—	—	+
33	+	+	0
45	+	+	0
Positive	4	5	2
Doubtful	2	..	1
Negative	1	2	..
No report		..	4

The bronchoscopic examination in 5 cases reported an endobronchial tumor present. In 2 cases the tumor was not visualized.

The bronchogram was definitely positive in 2 cases and doubtful in 1, and in 4 cases a bronchial visualization was considered inadvisable or unnecessary for a diagnosis.

In the 33 cases reported as negative for cancer cells, 13 were checked by surgical procedures such as lobectomy or pneumonectomy (see table 3). It will be noted that case 23 is not included in the total, for this is a tumor although benign. It is significant that the chest roentgenogram and bronchogram reported carcinoma present once and three times respectively. The bronchogram report in case 23 was "bronchial adenoma." Case 24 was a false negative cytologic diagnosis, and a subpleural carcinoma was found in the resected lung.

Some critics of the cytologic diagnosis of cancer have attempted to prove it of little value because of occasional false positive reports. It should be pointed out here that a total of 4 false positives were made by the chest roentgenogram and bronchogram in a series in which no false positives were made cytologically. The one false negative cytologic diagnosis

TABLE 3.—*Analysis of 13 Negative Cases*

Case No.	Diagnosis	X-ray	Bronchoscopy	Bronchogram
6	Actinomycosis	±	—	+
14	Tuberculosis	+	±	+
15	Bronchiectasis	—	—	—
19	Tuberculosis	—	—	+
23	Adenoma	—	+	—
24	Carcinoma	—	—	+
28	Bronchiectasis	—	—	—
29	Pneumonitis	±	—	—
31	Pleuritis, fibrous	—	—	—
34	Negative biopsy	—	±	—
38	Bronchiectasis	—	—	±
44	Bronchiectasis	—	—	—
46	Pneumonitis	—	—	—
	Positive	1	0	3
	Doubtful	2	2	1
	Negative	9	10	8
	Total	12	12	12

(case 24) has proved interesting, for the tumor mass was immediately beneath the pleura, and there is considerable doubt that it is a primary bronchogenic carcinoma. Its location makes the possibility of finding malignant cells in bronchial secretions highly improbable.

TABLE 4.—*Analysis of 6 Doubtful Diagnoses*

Case No.	Comment	X-ray	Bronchoscopy	Bronchogram
8	Tissue positive			
11	Unconfirmed	—	—	±
18	Sputums positive	+	±	+
36	Pleural fluid positive; sputum positive; x-ray therapy given	—	—	
37	Resolved	±	—	
47	Tissue negative; bronchiectasis	—	—	

Six cases were reported as doubtful (see table 4). In 3 cases (11, 37, and 47) the diagnosis of carcinoma has been unconfirmed or the condition has been proved to be inflammatory. The other 3 patients all have bronchogenic carcinoma beyond reasonable doubt.

Conclusions

1. The cytologic diagnosis of bronchogenic carcinoma has proved itself to be a highly valuable aid in our experience and that of other workers.

2. Considerable skill and experience are necessary for reliable diagnosis of bronchial smears and sputum.

3. In the present study no false positive diagnoses were made, and to date all tissues have confirmed the cytologic diagnosis, except for one false negative.

4. The ease in obtaining sputum makes this the material of choice in cases in which more drastic procedures are deemed inadvisable or the tumor site is inaccessible bronchoscopically. However, bronchial aspirate is preferable when available.

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EXAMINATION DATES SCHEDULED BY STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

The next examination of the Wisconsin State Board of Examiners in the Basic Sciences will be held on December 4 at the Plankinton House, Milwaukee, from 8 a. m. to 5 p. m. The last filing date is November 27.

An examination has been scheduled for April 2, 1949, at the Hotel Loraine, Madison, from 8 a. m. to 5 p. m. The last filing date will be March 26, 1949.

Later dates for examinations during 1949 have been scheduled for June 4, September 24, and December 3.

Benign Multiple Hemangiomas

By JOSEPH M. KING, M. D., JACK A. KLIEGER, M. D., and LEO R. WEINSHEL, M. D.
Milwaukee

J. M. KING

Doctor King, associate professor of surgery at Marquette Univ. School of Medicine, graduated from that institution in 1921. A fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, he also is surgical director of Milwaukee County Hospital.

J. A. KLIEGER

Doctor Klieger serves as an instructor in obstetrics and gynecology at Marquette University School of Medicine and is a member of the associate attending staff of Milwaukee County Hospital. He received his degree in medicine from Marquette University in 1940.

L. R. WEINSHEL

A 1937 graduate of Marquette University School of Medicine, Doctor Weinshel serves as senior resident in surgery at Milwaukee County Hospital. He is also on the staff of Marquette University School of Medicine as a teaching fellow in surgery.

MULTIPLE hemangiomas of the skin, pleura, liver, left leg, small intestine, and mesentery occurring simultaneously in a newborn infant (fig. 1) are a comparatively rare clinical picture. Therefore, we are presenting this case with its many unusual and interesting findings.

Report of a Case

A male Negro infant was delivered spontaneously, full term, and without difficulty, at the Milwaukee County Hospital, on Jan. 6, 1946. At birth, he weighed 6 pounds, 3½ ounces. His color and cry were poor.

Fig. 1.—Negro male infant at birth, revealing multiple hemangiomas of the skin and left leg.

Physical examination disclosed a tremendous dilation of the veins of the entire left leg and thigh, giving the extremity a peculiar distortion, and an increase in size to four times the normal appearance of the right lower extremity. The head, neck, chest, heart, lungs, and abdomen were essentially normal.

A diagnosis of cavernous hemangioma of the left leg was made, and the infant was treated in a routine fashion and, in addition, was given oxygen and vitamin K.

The leukocyte count of the blood was 5,000 per cubic millimeter; the hemoglobin measured 63 per cent; the erythrocyte count was 3,640,000 per cubic millimeter; the color index minus .87; and the platelet count 190,000. The Eagle and Kline tests were negative. (The patient's mother had tertiary syphilis, Kline 3 plus and Eagle plus, for which treatment had been rendered.)

Four days after birth, several new hemangiomas with petechiae developed over the skin of the face, chest, hands, and the right lower lid. The cavernous hemangioma of the left thigh appeared to be slightly larger in size, but the bones of the left lower extremity appeared to be free of involvement. The hip, knee, and ankle joints were freely movable and apparently without pathologic conditions.

On Jan. 17, 1946, he weighed 5 pounds, 12½ ounces. An x-ray of the left femur revealed a huge, soft tissue swelling on the inferior surface of the left leg. The femur, however, appeared intact and showed no evidence of bony changes. No abnormal gas shadows were visualized in the soft tissue area. A few suggestive calcific deposits were noted in the lower one-third of the soft tissue mass.

His course was downhill despite the fact that he was gaining weight. On Feb. 1, 1946, he weighed 6 pounds, 3 ounces. There was marked pallor of the

face, hands, and feet. A fontanelle puncture was performed to obtain blood for examination.

The leukocyte count was 8,300, with 14 per cent polymorphonuclear neutrophilic band cells; 1 per cent polymorphonuclear neutrophilic segmented cells; eosinophils, 4 per cent; lymphocytes, 59 per cent; monocytes 18 per cent; and plasma cells, 4 per cent. The hemoglobin measured below 49 per cent, and the erythrocyte count was 2,540,000 per cubic millimeter. The platelets totaled 120,000.

The blood smear revealed moderate anisocytosis, a few of the red blood cells looked spherocytic, and there were moderate polychromasia and marked poikilocytosis consisting of bizarre, stellate red blood cells and 6 normoblasts per hundred white blood cells. The morphologic changes of the red blood cells were suggestive of a hemolytic anemia, However, the distribution of leukocytes was incompatible with the usual picture seen in a typical hemolytic anemia. There was no toxic degeneration of the polymorphonuclear neutrophiles.

The prothrombin time was 21.4 seconds (control 13.6 seconds). The plasma looked markedly icteric. The prothrombin clot was of extremely poor quality, consisting of a few bits of solid material formed in the plasma. The coagulation time (Lee and White) was four minutes and twelve seconds, (normal, five to ten minutes). The bleeding time (Duke method) was 9 minutes, 50.8 seconds (normal 3–5 minutes).

On Feb. 3, 1946, a cannula was inserted into the right anterior medial malleolar vein and 60 cc. of whole blood administered slowly. The infant was seen by various members of the hospital staff who felt that the patient had a cavernous hemangioma, with prothrombin deficiency, prolonged bleeding time, and anemia. Amputation of the left lower extremity was considered, but, due to the patient's critical condition, surgical treatment was deemed inadvisable.

On Feb. 8, 1946, the hemangiomatous areas had increased in number so that there was now not only involvement of the left thigh and leg, but multiple lesions to the right big toe; right first, second, and third fingers; right lower eyelid; right side of scalp; right lower lip; right heel; and multiple lesions 1 mm. in diameter over scattered areas of the skin. The condition of the infant remained weak and feeble despite his weight of 6 pounds, 9¼ ounces. On Feb. 12, 1946, he weighed 7 pounds, 6 ounces.

The following days x-rays of the chest revealed no evidence of infiltration, consolidation, or pleural effusion. The heart was normal in size, shape, and position. X-rays of the wrists revealed that the bone age was consistent with the chronologic age of the patient. There was no evidence of pathologic involvement in any of the bones comprising this region.

The infant became progressively more anemic (table 1) pale, weaker, and feeble. He expired on Feb. 22, 1946.

Autopsy Findings

Autopsy findings revealed the following: The body was that of a 6 week male Negro infant, 45 cm. in length, who was well developed and poorly nourished.

The head was covered by sparse black hair. The scalp showed several small, soft, reddish black nodules averaging about 2 mm. in size. The ears and nose were without change. The right lower eyelid showed a single, small, reddish nodule on its external aspect. The eyes were not remarkable in appearance, and the pupils were round and equal. Nodules of a similar type were present on the undersurface of the right jaw and were particularly numerous on the neck. They were small, reddish black and shiny, and soft in consistency. They varied in size from less than 1 mm. to about 2 mm.

The upper extremities were thin and small. A few minute, reddish nodules, which looked like telangiectases, were present on the arms. The left lower extremity was markedly deformed by the presence of a huge mass involving the thigh, which was abducted to about a 90 degree angle. The mass measured 20.0 by 9.0 by 7.0 cm. It was nodular, soft, and cystic and had a bluish color in some of the thinner cystic areas. It was particularly evident on the anterior aspect and extended from the groin to the knee. On the metatarsophalangeal joint of the right first toe was a similar small, cystic, bluish nodule just under the skin. On section, the mass involving the left thigh was seen to contain a large quantity of fluid and coagulated blood. It collapsed almost in its entirety when incised, and was seen to be made up of a multiloculated cystic structure, the inner lining of which was smooth and grayish in appear-

TABLE 1.—*Hematologic Studies*

Date	Erythrocytes, 1,000	Hemoglobin, %	Leukocytes	Neutrophils, %	Eosinophils, %	Basophils, %	Lymphocytes, %	Monocytes, %	Blood platelets, x 1000	Prothrombin Time	Bleeding Time	Coagulation Time	Plasma Cells	Reticulocytes, %
1/ 9/46	3640	63	5000											
1/10/46									190					
1/25/36	3040	45.5	5450	47	1	1	35	16						
2/ 1/46	2540	—49	8300	15	4		59	18	120	21.4 sec.	9 min. 50 8 sec.	4 min. 12 sec.	4	
2/ 2/46	2360	40.5												
2/ 4/46	2000	—49	5550											2.2
2/ 6/46	2820	44	9300											
2/ 8/46	2470	40.5	7350											2.7
2/13/46	2600	—49	6400											
2/18/46	2940	36.5	7200											

2/1/46. Blood smear: Moderate anisocytosis: a few of the red blood cells looked spherocytic; moderate polychromasia; marked poikilocytosis, consisting of bizarre, stellate red blood cells, with 6 normoblasts per hundred white blood cells. Morphologic changes of red blood celll are suggestive of a hemolytic anemia; however, the distribution of leukocytes is incompatible with the usual picture seen in a typicas hemolytic anemia. There is no toxic degeneration of neutrophils.

ance except where there was attached thrombotic material. The musculature of the thigh on its ventral aspect was pushed aside by the cyst.

Microscopically the epithelium of the left lower extremity showed normal keratinization and the degree of basal pigmentation characteristic of the Negro type. The dermis likewise showed no changes. There was a thin but unbroken layer of subcutaneous adipose tissue. The tissues beneath the subcutaneous adipose layer were interrupted by irregular but well defined spaces of variable sizes, all of which were lined by simple endothelium resting on fairly thick fibromuscular walls. Most of these vascular spaces contained blood, often mixed with many leukocytes and thrombotic material. No evidence of cellular proliferation was present. The vascular channels were seen extending deep into the striated muscle, in some places completely separating muscle bundles, so that the latter formed bridges or trabeculae across the vascular spaces. In some areas there were small extravasations of blood into the interstitial tissue; this change appeared to be recent since no blood pigment deposits were present. The picture was that of a benign cavernous hemangioma.

Grossly and microscopically, except for the relative ischemia of the myocardium, there were no significant changes in the heart.

The parietal pleura on the right contained several reddish black, glossy nodules about 2 to 3 mm. in size. Aside from a few scattered areas of atelectasis, the lungs were normal.

The liver measured 10 by 7 by 3 cm. Its surface was smooth but close inspection revealed a peppering by minute pinpoint, reddish nodules, particularly over the surfaces of the right lobe in the anterior part. On section, several of these structures were scattered through the parenchyma. Microscopically, the cell cords were not remarkable in appearance. The sinusoids were prominent and contained, in addition to erythrocytes, many small, deeply stained round cells. Of the latter, the majority appeared to be lymphocytes, the remainder consisting of normoblasts. Scattered round cells were seen in some of the portal areas.

The spleen measured 5.0 by 3.5 by 1.5 cm. It was soft and pale. The only noteworthy feature was the presence of scattered, small clusters of erythroblastic cells. The lymph follicles were well developed and the sinusoids contained a fair amount of blood.

The kidney, adrenals, and the urinary bladder were normal in architecture.

The most striking change evident in the gastrointestinal tract was the presence of several wedge-shaped, reddish black, blood-filled nodules located on the mesentery at its attachment to the small intestine. These were about 1 cm. in width and flattened. The small intestine also showed no vascular reaction. On section of the small intestine, the lesions consisted of large, well defined cavernous hemangiomatous spaces, well filled with blood, located in the submucosa and extending through the muscularis into the tissue of the mesentery. From one-third to one-half the circumference of the bowel was involved. As in the left leg, the cavernous spaces were composed of fibromuscular walls lined by a single layer of endothelium. The muscularis was interrupted by the hemangioma. The mucosa was without change.

The right tibia revealed a moderately widened, slightly irregular epiphyseal line which was yellowish in color. Section through the epiphysis and upper part of the shaft of the tibia revealed a widening and irregularity of the epiphyseal line. The normal cellularity of the marrow spaces in the shaft was replaced by fibrous and granulomatous tissue, composed principally of plasma cells, lymphocytes and fibroblasts. Although actual gumma formation was absent, the granulomatous changes and the distortion of the epiphyseal line were characteristic of syphilitic osteochondritis.

Clinical Diagnosis.—The clinical diagnosis was malignant hemangioma.

Anatomic Diagnosis.—The anatomic diagnosis was (1) severe anemia; (2) multiple benign cavernous hemangiomas involving the left leg, skin, pleura, liver, small intestine and mesentery; (3) agonal intussusception; and (4) syphilitic osteochondritis, congenital.

Discussion

Hemangiomas vary greatly in structure and various types demand varying types of treatment. A rigid classification is almost impossible. The endotheliomas form a very poorly defined group of tumors, but there is no difference of opinion about the endothelial tumors which arise from blood and lymph vessels, the hemangioma or hemangioendothelioma, and lymphangioma or lymphangioendothelioma.

The hemangioma, or angioma, probably has its origin, according to Watson and McCarthy, in embryonic sequestrations of mesodermal tissue and grows by projecting buds of endothelial tissue. Two forms of hemangioma are recognized, the capillary and the cavernous. The age of onset varies from birth to adulthood. Hemangiomas should be eradicated early, chiefly because of their cosmetic importance and also because of the danger of hemorrhage and occasional invasive and metastasizing properties.

The capillary hemangiomas are growths which are really telangiectasis containing varying amounts of pigment. Histologically they present a picture of a closely lying network of capillaries which are made up of well differentiated endothelial lining cells which are large and swollen and which may be several layers in depth, bound together by a light connective tissue stroma and may or may not contain blood in the lumen. They occur most commonly in the skin, but also occur in the mucous membrane of the nose, lip, tongue, gum, or rectum, in which latter position severe hemorrhage may occur. Most of

them are found on the head or neck, where they often follow the distribution of the fifth nerve and remain fairly unilateral, rarely crossing the midline. They are present at birth and respond well to radiation in the first year. They rarely undergo progression and do not respond to x-ray or radium therapy after the first year for then they are not amenable to treatment.

The cavernous hemangioma is a mass of convoluted arterioles and venules with many cystic dilatations and sacculations lined by a single layer of endothelium filled with serum or blood. There is little connective tissue. The clinical forms of cavernous hemangioma are as numerous as the different tissues in which they occur, and they occur in all tissues except in cartilage, according to Kornmann.

The cavernous hemangioma is found most commonly in the liver where it may be multiple. These hemangiomas have also been found in the skin, in various organs, in lips, and in the subcutaneous tissue and underlying muscle.

The most common angioma of the internal organs is the cavernous form that occurs in the liver near its sharp lower anterior border, rather favoring the left lobe. It probably represents a hamartoma or developmental defect in the complicated vascular system of the organ. It may attain a diameter of 15 to 20 cm. Geschickter and Keasberg report many solitary small hemangiomas of the liver found at postmortem examination. It is likely to be mistaken for an infarct during autopsy or gross examination, but histologically it has the usual appearance of an angioma. Clinically it does not give rise to any symptoms.

Cavernous hemangiomas of the skin and subcutaneous tissues may be flat or elevated, and when superficial they are brilliant scarlet; if deeply subcutaneous, blue. Both skin and mucous membrane may be involved at the mucocutaneous junctions. If the lip is involved, a raised mass is formed, often of distinctly higher temperatures than the surrounding structures. They are usually soft, papillomatous, and spongy and when firmly compressed, undergo blanching.

Hemangioma of the lung is a rare condition, but it can be cured if seen early. It is more of an arteriovenous fistula, since its newly formed vascular channels connect the arterial and venous sides of the pulmonary circulation rather than having the blood pass through the capillaries into the alveolar walls.

In our case a segment of the small intestine and its mesentery were found to contain areas of cavernous hemangiomas extending into the muscular layer of the intestine, and this is a comparatively rare occurrence.

Cavernous hemangiomas, in contrast to the capillary hemangiomas, respond to treatment. The form of radiation therapy in this group varies with the lesion. As a rule the superficial cavernous hemangiomas respond to radium, while the deep lesions respond best to roentgen rays, followed, if necessary, by radium.

The patient in the case presented in this report was not given any therapy because of the severe anemia, and it was believed that this was a case of malignant hemangioma, due to the multiple outcropping of new areas of hemangioma over the entire body shortly after birth.

The congenital syphilitic osteochondritis had no bearing in the production of these hemangiomas. There were no other anatomic findings attributable to syphilis.

Summary

1. A brief review is presented of hemangiomas of the capillary and cavernous type.

2. A case of an unusually large hemangioma of the left lower extremity with multiple cavernous hemangiomas involving the skin, pleura, liver, small intestine, and mesentery is presented in detail with autopsy findings.

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Some Modern Aspects of the Treatment of Bulbar Poliomyelitis

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THE treatment of the so-called bulbar form of poliomyelitis has been the subject of much discussion and controversy. For many years the mechanical respirator or "iron lung" was the only therapeutic device considered.

During the 1946 epidemic in the Midwest, a total of 183 cases of bulbar poliomyelitis were admitted to the University of Minnesota hospitals and studied jointly by a research committee in which the departments of physiology, neurology, pediatrics, and physical medicine took part. This joint attack has done much to clarify one's ideas on the therapy of bulbar poliomyelitis. While much of the material collected was known before, the application of clearly defined physiologic principles has provided a logical approach to this clinical problem.

According to Baker[2] patients with bulbar poliomyelitis should be divided into five groups, even though considerable overlapping between groups exists. They are (1) bulbar, cranial nerve nuclei group; (2) bulbar, respiratory center group; (3) bulbar, circulatory center group; (4) bulbar encephalitic group; and, (5) combined bulbar, cervical cord group.

1. In lesions of the first type the seriousness of the situation depends on whether or not the tenth nerve (vagus) is involved. Involvement of the facial nerve may require protective measures for the cornea, but special treatment is otherwise rarely necessary. Involvement of the vagus nerve results in difficulty in swallowing, and faulty innervation of the larynx, regurgitation, and defective speech occur. From the respiratory standpoint, this results in obstruction of the upper airways. The therapeutic effort then should be directed toward the upper airways. It should be clear that in uncomplicated cases the respirator is of little use. Clearance of the upper airways should be done as soon as possible. Baker and others[3] suggest that in these cases tracheotomy should be seriously considered. It should be emphasized that this should not be delayed until the patient is in extremis. Sudden apposition of the vocal cords can occur in these patients. This may be the equivalent of muscle spasm which is so often seen in the muscles of the extremities.[4] Other methods of providing air passage, such as intubation, can be used. The significant thing is to realize that patients of this type will not be helped by the respirator. On the contrary, the respirator, by increasing the negative pressure already provided by the respiratory muscles, may increase the danger of aspiration and pulmonary edema.

2. In those cases in which involvement of the respiratory center occurs, oxygen therapy is indicated. These patients usually show involvement of cranial nuclei earlier in the disease. Symptoms of impending failure of the respiratory center are anxiety, restlessness, increasing pulse rate, and a small elevation in blood pressure. It is important to realize that these symptoms may be caused by hypoxia. It has been shown that hypoxia can occur without cyanosis. It is at present possible to follow the changes in oxygenation of the blood with the Millikan oximeter.[5] The Millikan oximeter uses the difference between the hemoglobin and oxyhemoglobin absorption spectrum. The small measuring unit, which is attached to the ear, contains a light source which projects a beam of light through the ear lobe. The light then falls on two photoelectric cells which have been made to indicate hemoglobin and oxyhemoglobin respectively by the aid of special light filters. A bridge circuit and galvanometer measure the oxyhemoglobin content of the blood. The instrument was designed by the late Doctor Millikan, professor of physiology at Vanderbilt University and adapted for recording in poliomyelitis patients by Doctor Hemingway and his co-workers at Minnesota.[6]

As the involvement of the respiratory center progresses, increasing periods of apnea occur, atelectasis and pulmonary hemorrhage may occur, and cyanosis now becomes apparent; oxygen should be used to a maximum of 60 per cent and only in emergencies should 100 per cent oxygen be used. Oxygen exchange is increased by positive expiratory pressure of 2 to 6 cm. of water. It is possible, however, that chest excursions cannot be adequately maintained against this positive pressure, particularly if the respiratory musculature has been weakened by the disease. In this case the mechanical respirator should be used to overcome this difficulty. Adequate oxygenation of the blood as measured by the oximeter is indication of adequate treatment.

3. In those patients in whom the circulatory center is primarily involved, the patient presents a dusky red appearance. The pulse rate is out of proportion to the temperature. As the involvement progresses, the blood pressure drops to shock levels, the pulse becomes imperceptible, and the skin becomes cold and clammy with mottled cyanosis. Treatment is not very effective. Out of 12 patients in the Minnesota reports, 10 died.

4. Encephalitic involvement appears to be quite common in bulbar poliomyelitis. However, symptoms such as restlessness, hyperexcitability, tremors, and twitchings should first be considered the result of

cerebral hypoxia. Only if the symptoms persist after satisfactory oxygenation has been obtained should the diagnosis of bulbar encphalitic poliomyelitis be made.[7] This hypoxia may be the result of the obstruction of the airways, pulmonary edema, ateletasis, or failure of central respiratory or circulatory control. When this is recognized, adequate treatment should be instituted, and the oximeter is again a most helpful instrument in supervision of these therapeutic procedures. It should be stressed again that cyanosis is an inadequate indication for hypoxia; the latter can occur long before cyanosis becomes apparent.

It has been shown that with decrease in oxygen saturation of hemoglobin from 96 to 90 per cent, the partial oxygen pressure in the plasma falls from 100 to 60 mm. of mercury, which, of course, results in a considerable reduction in the oxygen uptake of the nerve cells. Cyanosis does not occur until the oxygen saturation of hemoglobin has been reduced to 80 per cent. At that level the flow of oxygen from plasma to nerve cells may have been reduced by as much as 65 per cent. Severe hypoxia of nerve cells can thus occur before cyanosis becomes apparent.

The cortex is more sensitive to hypoxia than the medulla.[8] However, in chronic anoxia the direct influences on the respiratory center become more important than in acute anoxia, and disease of the nerve cells can be expected to be more damaging to respiratory function than in acute anoxia.[9]

To support the bulbar centers, oxygen should be administered when anxiety, restlessness, and increasing pulse rate become apparent. Oxygen should be administered by nasal catheter after it has been moistened by passing through a water trap. A soft rubber catheter (sizes 12 to 14 French may be used) is inserted, with oxygen flowing slowly, for a distance of 1½ inches less than the distance from the nostril to the external auditory meatus in an adult and about ½ to 1 inch less in a child. This distance should be measured in the individual patient and the catheter lubricated before insertion. The catheter should then be brought up to the forehead and fixed with adhesive tape. The flow of oxygen is then increased to 4 to 6 liters per minute. When it is evident that the disease is no longer progressing and hypoxia-producing episodes have ceased, the oxygen may be gradually reduced and then stopped if the patient remains comfortable without it.

5. Involvement of the cervical cord in bulbar poliomyelitis creates special problems. It may lead to weakness or paralysis of the intercostal muscles and the diaphragm. It is obviously here that the mechanical respirator is indicated. Again it should be stressed that one will have to be sure of adequate air passage if the respirator is to be beneficial; otherwise the increased negative pressure in the alveoli may produce acute pulmonary edema. Use of the respirator does not interfere with a tracheotomy if it is done high, or a special cone-shaped respirator collar can be used, or a thick-walled rubber tube can be connected to the tracheotomy tube and be brought out through the respirator collar.

Particularly in these patients but also in other cases in which tracheotomy is performed for bulbar poliomyelitis, difficulty is experienced from drying of bronchiotracheal secretions. The long duration of the respiratory involvement makes this particularly important. Bronchoscopy has proved helpful in selected cases. It has been helpful to nebulize penicillin in saline solution down the trachea. Atropine is not desirable, since it makes the mucus more viscous and its elimination more difficult.

Atelectasis is one of the most frequent and serious complications in poliomyelitis patients suffering from primary respiratory or bulbar paralyses. The development of atelectasis depends on (1) the inability of the patient to cough and (2) the presence of infection in the respiratory tract. Since the patient cannot cough adequately, it is impossible to keep the respiratory tract free from secretions which are evident in increasing amounts when infection is present. The partial obstruction of a bronchus with mucus produces a ball valve action which allows air to leave but not to enter the bronchus, so that the lung area involved is emptied of air with the production of atelectasis. When obstruction is complete, no air enters and the air in the alveoli is eventually absorbed. The collapsed lung areas then become fertile fields for the growth of bacteria and pneumonia.

Examination of these patients demonstrates either diminished or absent movement of the intercostal muscles or the diaphragm. Dullness to flatness is noted on percussion, and the breath sounds are diminished over the involved lung areas. X-ray or fluoroscopic examination will reveal a shift of the mediastinum to the affected side. Postural drainage and expectorants may be tried, but if much respiratory distress exists bronchoscopic examination and aspiration of the obstructing secretions is indicated. To prevent pneumonia, sulfadiazine and penicillin should be administered prophylactically to all poliomyelitis patients with respiratory infections complicating bulbar or respiratory paralysis. These patients must be protected at all times from contact with individuals with upper respiratory tract infections.

Kubicek and co-workers[10] at the University of Minnesota have designed special inhalator equipment for use with the tracheotomy tube. An attachment with four openings is used. One opening connects with special spring clips on the inner tracheotomy tube. One opening is closed with a rubber stopper and is used for aspiration of secretions. The other two openings connect with the inspiratory and expiratory systems respectively. The inspiratory system contains a breathing reservoir bag, a valve and condensation trap, and a humidifier. The water in the humidifier is heated to 35 C. and gas is introduced through 3 feet of perforated rubber tubing, below the water surface. Gases used are 80 per cent

helium and 20 per cent oxygen and pure oxygen mixed in appropriate concentrations or an air oxygen mixture. The rationale for the use of helium has been described.[11] The expiratory system contains a water trap and a device to introduce positive pressures of 2 to 6 cm. The importance of positive pressures in the presentation of lung edema is well known. It should be realized that muscle weakness in poliomyelitis may make it difficult for the patient to overcome this pressure. Pressures over 2 cm. should be used with caution and the respirator may have to be used in coordination with the tracheotomy inhalator. The practical use of the respirator need not be described here; an excellent booklet on the subject is available from the National Foundation for Infantile Paralysis. A word of warning should be added on the need for adequate training of the personnel in the handling of the respirator. Too often this does not include the handling of the respirator in case of current failure. The nurse must know immediately what to do; warning devices for current failure, with which most modern respirators are provided, are of little use if the nurse technician needs to look up an instruction sheet in order to find out what to do. The respirator is a life-preserving instrument. In the hands of the untrained, it becomes a dangerous gadget.

Skillful bedside nursing is of the utmost importance in producing relaxation and allaying the apprehension of the patient with poliomyelitis. Ministering to the emotional as well as the physical needs of the patient falls for the most part on the shoulders of the nurse. She must be trained to look for the early signs of involvement of the respiratory and circulatory centers in her patients as well as in the mechanics of the respirator.

Drug therapy has little place in the handling of bulbar poliomyelitis Sedatives should hardly be necessary and should on the whole be avoided, particularly in patients with diseased nerve cells.

Caffeine sodium citrate in doses of 10 mg per kilogram of body weight subcutaneously or intravenously may be given at one half to one hour intervals in patients with impending respiratory failure.[12]

It will be clear that in the patient with bulbar spinal poliomyelitis, the bulbar symptoms should dominate the therapeutic picture. Nobody will deny the importance of early physiotherapy in spinal poliomyelitis. Insistence on the treatment of spastic or paralytic leg muscles when the patient's life is at stake can hardly be considered sound medical practice. This goes particularly for hot packing. Hot packing requires handling of the patient and sometimes produces postures which are not ideal for easy respiration. Use of hot packs may increase the oxygen requirements of the body, and if the patient suffers from hypoxia this would be undesirable. The position of the patient in bed should again be determined in the first place by the requirements of easy respiration. Medical judgment will have to determine the relative importance of the bulbar and spinal symptoms in the individual patient.

If hypoxia-producing episodes such as choking and gagging can be eliminated during the acute febrile stage of bulbar poliomyelitis, there is an excellent chance for complete recovery. Therefore, all fluids and food by mouth must be eliminated. The patient should be placed in the Trendelenburg position at an angle of 30–40 degrees, preferably in the prone position to facilitate drainage and aspiration of saliva and mucus. Special nursing should be secured so that the patient may be watched constantly and aspiration of secretions performed as often as necessary to maintain a clear airway. Nutrition is maintained with 5 to 10 per cent glucose solution intravenously or glucose solution 5 per cent and normal saline equal parts subcutaneously. Eight hundred to 1,000 cc. per twenty-four hours may be given to a child and 1,500 to 2,000 cc. to an adult. More fluid tends to increase the amount of saliva and mucus.

Tube feedings should be avoided during the acute illness and should not be attempted until the temperature has remained normal for forty-eight to seventy-two hours and progression of paralysis has ceased. Earlier use of tube feedings is contraindicated because of the tendency of these patients to vomit. Since they are unable to swallow, aspiration into the trachea may be the sequel of such attempts early in the disease. Blood transfusions, plasma, and amino acids may be administered intravenously to support the patient until his ability to swallow returns. Parenteral vitamin therapy should supplement the fluid administration.

When the patient is able to swallow his own saliva, sips of clear water and diluted fruit juices may be started. If no choking or regurgitation occurs, clear broth, apple sauce, jello, and junket may be gradually added. Milk is best avoided in the early stages of recovery because it tends to stick with mucus in the mouth and pharynx.

A word of caution should be said about the transportation of patients with evidence of bulbar paralysis. If such a step is necessary to obtain adequate treatment for the patient, he should be accompanied by a physician or nurse who has facilities available for the aspiration of mucus and the administration of oxygen. Such professional administration will help considerably to relieve the apprehension of the patient and perhaps save his life.

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THIRD COUNCILOR DISTRICT TO MEET IN MADISON DECEMBER 9

O. O. MEYER

The Third Councilor District, comprising Dane, Columbia, Marquette, Adams, Green, Rock, and Sauk counties will hold a district meeting at the Park Hotel, Madison, on December 9, it was recently announced by C. O. Vingom, M.D., Madison, councilor.

A scientific program has been arranged for the late afternoon, to be followed by a dinner and an evening address on "Anemias—Present Status of Therapy," by O. O. Meyer, M.D., professor of medicine, University of Wisconsin Medical School.

The afternoon scientific program will consist of the following speakers and topics:

4:00–4:30: "Endocrine Therapy in Gynecology": F. Jackson Stoddard, M.D., Milwaukee
4:30–5:00: "Back Strains and Sprains": J. K. Stack, M.D., Chicago
5:00–5:30: "Care of Prematures in Everyday Practice": H. N. Sanford, M.D., Chicago

Doctor Stack is appearing under the sponsorship of the Industrial Hygiene Unit of the State Board of Health; Doctor Sanford is appearing under the sponsorship of the Bureau of Maternal and Child Care of the State Board of Health, while the Council on Scientific Work of the State Medical Society is providing the services of Doctors Stoddard and Meyer to the program.

All physicians of the Third District who have not already done so are urged to make reservations *now*, so that proper dinner arrangements can be made. The cost of the dinner is $3.00 per plate, including gratuities. There is no separate registration for participation in the scientific program, and all physicians in the Third District are urged to attend.

If you have not already made your dinner reservation fill out the coupon at the bottom of the page, and return it to C. O. Vingom, M.D., Madison, *before December* 5. Make your check payable to the State Medical Society of Wisconsin.

----------DETACH AND MAIL WITH YOUR CHECK----------

C. O. Vingom, M.D,
c/o State Medical Society of Wisconsin
704 E. Gorham Street

Dear Dr. Vingom:
Attached is my check of $3.00 to cover the dinner for the Third Councilor District Meeting at the Park Hotel, Madison on the afternoon and evening of December 9.

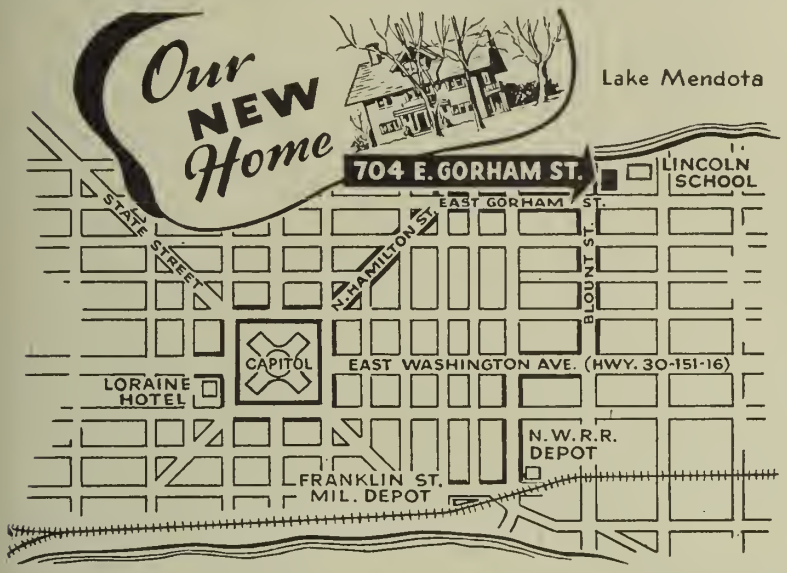
Signed _____

City _____

The
MEDICAL FORUM

The Wisconsin Medical Journal — November, 1948

AMA TO DECIDE ON BLUE CROSS-BLUE SHIELD PROPOSAL FOR NATIONAL INSURANCE COMPANY



HERE'S HOW to reach the new offices of the State Medical Society of Wisconsin. The above map shows the location of the society's home at 704 E. Gorham St. The building houses the medical society and its agencies, Wisconsin Physicians Service and Wisconsin Veterans Medical Service Agency.

House Requests State Civil Disaster Plan

Milwaukee, Oct. 6—The first move in the development of a complete civilian defense and disaster program for Wisconsin was made by the House of Delegates at the annual meeting when it directed the Committee on Military Medical Service to meet with the Governor, and recommended the establishment of a state-wide committee for civil defense and disaster planning.

The committee is to further recommend that the medical aspects of this planning be coordinated through a State Medical Society committee to be known as the "Committee on Military and Disaster Medical Service," and to consist of six members, two of whom shall be the State Surgeon and the State Health Officer.

Talking on Socialized Medicine?

If you need material for speeches or papers on voluntary health insurance or compulsory sickness insurance write to the State Medical Society for a copy of the list of reference material entitled:

"Voluntary Health Insurance vs. Compulsory Sickness Insurance"

It lists books, pamphlets, debates, radio talks, senate hearings, foreign references and many other sources of the best up-to-date information on socialized medicine or voluntary health insurance.

Write for it today!

Vingom Offers Resolution to Require That Blue Shield Commissioners Be Physicians

French Lick, Ind., Oct. 26—Immediate action on a proposal for a new Blue Cross-Blue Shield Association and an affiliated national insurance company was delayed at the French Lick Blue Cross-Blue Shield Conference when the Blue Shield Commission presented three resolutions recommending that final action not be taken until the plan has further study.

The resolutions adopted without debate and support by Wisconsin Physicians Service representatives at the conference are as follows:

"1. It is recommended to the conference of plans that the proposals for a Blue Cross-Blue Shield Association and Blue Cross-Blue Shield Health Service, Inc., be thoroughly discussed by the member plans but that final action not be taken at this conference.

Ask Further Study

"2. It is recommended that after discussion of the Blue Cross—Blue Shield Association and the Blue Cross-Blue Shield Health Service, Inc. by the conference of plans that the proposals be referred to the component units of Associated Medical Care Plans for discussion and an expression of their opinion to the Commission; and it is further recommended that printed copies of the proposals be distributed in quantity to the plans for their further study and conference with their sponsoring medical societies.

"3. It is recommended to the conference of plans that the proposals for a Blue Cross—Blue Shield Association and Blue Cross-Blue Shield Health Service, Inc. be referred to the House of Delegates of the American Medical Association at the St. Louis Interim Session or any subsequent session;

(Continued on page 7)

Begin Appointment of Medical Advisors to Serve New State Selective Service System

Selective Service Director Explains Physicians' Duties

Madison, Oct. 29—The selection of medical advisors to local county induction boards is being accomplished through cooperation of the State Medical Society with the State Selective Service System, reports Dr. Frank L. Weston, chairman of the Committee on Military Medical Service.

Reactivation of Selective Service measures means that "once again the physicians of Wisconsin will be called upon to render a valuable service to their nation by aiding in the selection of those who are physically and mentally fit for service," he said. Medical advisors will serve without compensation.

Upon request of the State Selective Service Director, Col. Bentley Courtenay, Madison, the Councilors of the State Medical Society have recommended member-physicians in each county who might agree to serve in the capacity of medical advisors.

Will Screen Inductees

Under the Selective Service System these men will not be required to examine all inductees as was done during World War II. Col. Courtenay explained that medical advisors will screen all inductees at the county level. They will be supplied with a list of "disqualifying obvious defects and manifest conditions," the presence of any one of which will disqualify an inductee for draft.

The purpose of this list of disqualifying disabilities is to save taxpayers' money by not sending to armed forces examination centers men who obviously could not pass a physical examination.

Col. Courtenay said that medical advisors would be chosen in the following manner:

From lists obtained from the State Medical Society and supplemented by the knowledge of physicians in their own area, each county induction board will recommend to the State Selective Service System the names of the physicians it wishes to have appointed as medical advisors. These names will be forwarded to Washington where the physicians will receive

Col. Courtenay.

certification and appointment from the President.

Col. Courtenay stated that medical advisors will do mostly "paper work" and will probably be asked to give a few hours a month at their local induction board where the physical records of each inductee will be available. The medical advisor will merely check the medical evidence in these records and upon the information presented there make his determination as to whether the man will be rejected or sent on for a complete physical examination at the armed forces examination center.

Young Doctors Obligated to Serve Armed Forces

Urge Men to Volunteer as Soon as Possible

Milwaukee, Oct. 6—Young physicians with no previous military service who received all or part of their medical education at the expense of the government have a moral obligation to volunteer for military service as soon as possible, the House of Delegates declared, when it approved a resolution submitted by the Committee on Military Medical Service, of which Dr. Frank L. Weston, Madison, is Chairman.

The recommendation was made in light of the difficulty being encountered by the armed forces in obtaining sufficient physicians to provide adequate medical care under the new Selective Service program. The committee pointed out that unless the armed forces obtain additional doctors in the required numbers, it may become necessary to resort to draft.

To continue the medical profession's record of being able to meet the need on a voluntary basis, the House recommended that former ASTP or V-12 medical students who completed their education at government expense, but were not called for service, make an effort to repay this obligation by enlisting for a short period of service.

FARM BUREAU ASKS 75% ENROLLMENT IN WISCONSIN PLAN

Already Have 15,000 Covered

Madison, Oct. 25—The Board of Directors of the Wisconsin Farm Bureau Federation recently passed a resolution urging the enrollment of at least 75 per cent of its members in the Farm Bureau insurance program, the Wisconsin Plan. The resolution stated:

"Whereas this board recognizes the need of an effective Farm Bureau health program and is proud of the tremendous good that has been accomplished even in the first year of its existence, and

"Whereas the program has proved itself effective in reducing worry and encouraging better health and accident care,

"Resolved that it is the earnest desire of this board that not less than 75% of the entire membership of Farm Bureau in Wisconsin shall be actively enrolled in the health improvement societies and in the health insurance program by November, 1949, and that the full support of the entire Wisconsin Farm Bureau be pledged to assist the Associated Women in bringing these programs to every Farm Bureau member in the state and in achieving the above goal."

About 300 claims a month are being handled by the health department of the Farm Bureau in settlement of Wisconsin Plan bills, Mr. Hal Kautzer, Director of the department, has reported. Almost $15,000 in claims is being handled each month.

Portage County recently began the 30th county in the state in which more than 100 Farm Bureau members have enrolled in the Wisconsin Plan. This brings Wisconsin Plan coverage through the Farm Bureau to more than 15,000 persons, Mr. Kautzer said.

DOCTOR'S LAMENT
1548–1948

When the sick man lies abed
distraught with pain,
And dismal Death is clutching
at his throat,
He likens me to God, and all his
house
Kneel down and do me reverence.

When easier lies his head, and
icy death,
Removes his hand and warm
the blood rebounds,
He blesses me as messenger of
God,
And Holy Angel from ethereal
high.

But when the full and rosy
touch of life
Bestirs his flesh and puts his
soul to sleep,
He greets me as a man, though
one of might,
And versed in all the Wisdom
of the world.

And then at last when recompense is asked,
He passeth me in dread, for Lo,
to him I stand,
A devil horned from out the
lowest depths.

—From a 16th century Dutch manuscript.

SOCIETY STUDIES MENTAL HOSPITALS

Madison, Oct. 27.—The legislative council subcommittee on welfare has asked State Medical Society and University of Wisconsin medical school officials to study the state mental hygiene program with a view to obtaining higher standards of care for patients in mental hospitals in Wisconsin.

A medical society committee on mental hygiene, institutional care, public welfare and state departments, whose chairman is Dr. H. H. Christofferson, Colby, is centering its study on the policies and procedures relating to personnel, physical facilities and treatment of patients in the state's hospitals for the mentally ill.

Other members of the committee are Drs. B. J. Hughes, Winnebago; O. H. Epley, New Richmond; W. A. Munn, Janesville, and P. R. Minahan, Green Bay.

One of the major objectives of the committee is to formulate a program in cooperation with the University of Wisconsin medical school to provide the mental hospitals with rotating residencies in neuropsychiatry. This will give the hospitals more professional help and provide teaching opportunities for medical students interested in psychiatry.

The committee will also study possible expansion of follow-up social services from the main mental disease treatment hospitals at Mendota and Winnebago, and supervision of more than 30 county mental hospitals under a division of the state department of public welfare.

Board Gives Ruling on Licensing of Physicians Educated in Foreign Schools

River Falls, Nov. 5—The State Board of Medical Examiners has been advised by its legal counsel of its statutory duty in connection with examining and determining the qualifications of applicants for a license to practice medicine and surgery, or osteopathy and surgery, whose training has been acquired in a foreign country.

The highlights of this opinion are:

1. The Board cannot apply a lesser standard of educational and professional training to applicants having their medical education in foreign countries than is applied to graduates and citizens of this country.

2. The Board must consider the application for license of an immigrant who has secured his first citizenship papers.

3. The Board must determine whether the school attended by the immigrant was a reputable institution, and whether the immigrant has all educational prerequisites of equivalent value to those required of American or Canadian applicants. This means verifying his credentials and determining whether the applicant actually took the courses that the credentials represent.

The primary burden is upon the applicant to establish his qualifications. The Board may make any investigations it advises necessary to ascertain the authenticity of his certifications.

If the Board is satisfied with the immigrant's qualifications, it must then examine the applicant in the same fashion as it examines those who graduate from the University of Wisconsin or Marquette Medical Schools. If the applicant successfully passes the examination, he may then be licensed.

The Board said that the law under which it functions is designed for the protection of the public and is a reasonable exercise of the police power of the state, in assuring to the public that unqualified practitioners will not be given the official seal of approval of the State of Wisconsin.

The complete text of the ruling by the State Board of Medical Examiners will appear as an editorial in the December issue of the Wisconsin Medical Journal, according to Dr. C. A. Dawson, River Falls, Secretary of the Board.

I CAN'T. PAY!

Too often this statement is absolutely true. Yet another patient earning far less money *can* pay. There is a reason.

For 56 years Time Insurance has provided the means of keeping Wisconsin families solvent when sickness or accident strikes.

Time insures more Wisconsin people in the average income bracket than any other company—a record accomplished only by selling quality merchandise.

The Time Insurance Company

213 W. Wisconsin Ave.
Milwaukee 3, Wis.

FORUMETTE

NINE MONTH COURSE FOR PRACTICAL NURSES OFFERED AT KENOSHA SCHOOL

No Difficulty Finding Jobs, Declares School Director

Practical nursing is opening new doors for usefulness to young girls and older women who enjoy caring for others but do not wish to become professional nurses.

The Kenosha School for Attendants, sponsored by the School of Vocation and Adult Education and the Kenosha Hospital, was the first school for practical nurses to be established in the State of Wisconsin. Its first class opened in January, 1947.

The purpose of the school is to prepare 'attendants or "practical nurses" to care for chronic, convalescent, the aged patients with minor illnesses, mothers and infants and well children. Upon completion of the prescribed course the students may take the Wisconsin licensing examination for attendants, and if passed successfully, will be issued a license to practice in Wisconsin as trained practical nurses.

Licensed attendants are in great demand in hospitals, private homes and convalescent and nursing homes, clinics, doctors' offices and in industry. Graduates from approved schools for attendants will find no difficulty in securing work in these fields, declares Miss Lorraine Regenfuss, Director of the Kenosha school.

No Tuition Fee

A nine-month course is provided at Kenosha, the first three months being spent in study and classroom practice from 7 a.m. to 3 p.m. Monday through Friday. The last 6 months are spent in supervised practice on the hospital wards.

The curriculum consists of the following: elementary nursing arts, 80 hours; housekeeping, 48 hours; foods and cookery, 56 hours; normal structure and function of the body, 20 hours; personal hygiene, 20 hours; care of the convalescent, chronic and aged patient, 12 hours; care of children, 10 hours; care of mothers and infants, 10 hours; occupational diversion, 10 hours; ethics and personal development, 36 hours, and supervised practice in wards.

There is no tuition fee at the Kenosha Practical Nursing School. However, the student is expected to pay the cost of uniforms, about $35, plus the cost of a text book and small incidentals.

To enter the school a student must be a citizen of the United States, age 18 to 35 and a high school graduate of good moral character. A birth certificate must be presented and a personal interview is desired whenever possible.

A complete physical examination is given each student upon entrance and before graduation from the school. This service is free. A two-week vacation is arranged to fall during the five months of training and students are free to go home on weekends when they do not have classes.

The Kenosha Hospital provides free board and lodging at the nurses' home. A pleasant and home-like atmosphere prevails in the dormitory facilities. All linens are furnished by the hospital.

Practical nursing students wear a uniform of brown chambray with white collar and cuffs and white stockings and shoes. After six months a brown chambray cap trimmed with white is added after the student's work is satisfactory.

New classes are taken in twice a year, in March and in September. At the present time fifteen students are enrolled. Application forms may be obtained from Miss Lorraine Regenfuss, Director, Kenosha School for Attendants, 6308 Eighth Avenue, Kenosha.

Three recent graduates of the Kenosha School for Practical Nurses show off their attractive uniforms. New classes are enrolled each March and September. Students live in the nurse's dormitory and receive practical instruction at the hospital.

Postpone Nurses Meeting Until February 4–5

Madison, Nov. 5—The Institute of Nursing, originally scheduled by the planning committee of the four sponsoring organizations, the State Medical Society of Wisconsin, the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals and the Wisconsin State Nurses Association, was postponed from November 12–13 to February 4–5 because it was impossible to bring together representatives of all organizations.

Further details on the meeting will be available in the December issue of the Medical Forum.

OREGON SERVICE PLAN IN ANTI-TRUST SUIT

Charged With Monopolizing Medical Care Insurance

Portland, Ore., Oct. 19.—The Oregon State Medical Society, Oregon Physician's Service, eight county medical societies and eight individual doctors have been charged with violating the Sherman antitrust act.

A civil suit filed in United States district court by the justice department for Attorney General Tom Clark accused the defendants of conspiring to "deprive the public of the opportunity to acquire prepaid medical care insurance" from anyone but themselves.

Will Fight Suit

The suit "absolutely" will be fought, a representative of the Oregon Physicians' Service said. Oregon Physicians' Service, organized in its present form in 1941, is a non-profit corporation sponsored by the medical society. It has 105,000 members in Oregon, and allows subscribers to choose their own doctors. Ninety per cent of Oregon's doctors are affiliated with the plan which is approved by the AMA.

The complaint charged that since Jan. 1, 1936, "defendants have attempted to and have been engaged in a combination and conspiracy to, restrain and monopolize interstate trade and commerce in the business of selling and furnishing prepaid medical care in the state of Oregon and in other states in violation of the Sherman act."

Claim Restrictions

Those named were specifically charged with trying to limit the scope of prepaid plans, hindering other such organizations, restraining residents of Oregon, Washington and California from entering into plans not sponsored by the Oregon doctors, restricting doctors under other plans as to hospital facilities and preventing their cooperation with other plans.

Attorney General Tom Clark commented that "this suit is brought in an effort to remove restrictions which prevent the people from selecting one type of prepaid medical care over another on a free market."

Seek to Insure Proper Expert Medical Testimony

Milwaukee, Oct. 6—A program to insure proper expert medical testimony in court cases was established by the House of Delegates at the annual meeting.

The program was based on a study of the medical testimony problem by the Committee on Grievances, headed by Dr. J. W. Prentice, Ashland, and representatives of the State Bar Association. The committee report adopted by the House stated that instances of inaccurate testimony by physicians are infrequent and involve so many factors "that it is impossible to attach the blame upon one particular individual."

The House decided that the Committee on Grievances shall assume jurisdiction in any proceeding where those licensed to practice medicine and surgery are qualified as expert witnesses and where the judge, presiding official, any of the participating attorneys or another physician expresses in writing, for transmittal to the committee, that an expert has falsified in testimony or demonstrated incompetence.

Four Alternatives

In such cases the name of the case will be secured, and at the expense of the Society, a certified copy of the testimony obtained, together with other pertinent material. The name of the reporting party will be kept confidential. After study of the case the committee may take action in the following manner:

1. Determine that the witness testified properly.
2. Call the witness before the committee for censure or warning.
3. Demand further investigation with state agencies.
4. Determine that the problem involves lawyers and refer the matter to the appropriate body of the State Bar Association.

REVISE COUNTY INFIRMARY BILL

SMS Will Urge Legislation for Care of Aged Infirm

Madison, Oct. 21.—The State Medical Society has modified its plans to introduce a legislative bill calling for construction of county infirmaries for the aged and chronically ill because there are indications that counties do not have sufficient funds to undertake institutional programs covering both types of care.

The new version of the bill will propose county infirmaries only for the care of the aged infirm. Witnesses at a recent hearing of the legislative council subcommittee on welfare testified that the most immediate need is for institutional care of bedridden aged persons, many of whom are now being committed to county mental hospitals because no other facilities are available.

Robert B. L. Murphy, counsel of the medical society, told the legislative committee that the cost to the state for the first two years of a plan to care for both the aged and chronically ill would be about $511,000 using beds in existing institutions.

He added that if the 12,000 "totally incapacitated" persons in the state all were taken care of under this program, the state's share might reach as much as $10,000,000 a year. Restricting the bill for the time being to care of the aged will materially reduce the cost to the taxpaper.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions
References furnished on request.

Wisconsin is First With Law for Aid to Disabled

Statewide Aid Program Explained by Official

Madison, Oct. 29—Wisconsin is the only state to enact specific legislation providing aid to certain types of disabled persons on a statewide basis, declares John W. Mannering, administrative assistant in the division of public assistance of the Wisconsin department of public welfare.

Known as aid to totally and permanently disabled persons, the law has been operating for 2½ years, Mr. Mannering wrote in a recent issue of *Public Welfare.*

It provides a maximum of $80 a month cash aid to persons found by medical authority to be so totally and permanently disabled physically as to require constant and continuous care.

Administered Locally

To receive benefits a person must be between 17 and 64 years of age, a citizen, resident of the state for at least one year before applying for aid. He cannot be an inmate of a public institution or have legally responsible relatives who are able to undertake his support. He may have a home of reasonable value and other resources not to exceed $1,000.

The program is administered by county agencies which handle social security aids with the State Department of public welfare actually determining which applicants are so *"totally and permanently physically disabled as to require constant and continuous care."*

Strict Interpretation

The county department is required to obtain a complete medical report from a licensed physician on each applicant believed to be eligible. The agency supplements this report with its observation of the applicant's condition and submits them to the state agency for review by a medical consultant who advises as to eligibility, Mr. Mannering said.

Mr. Mannering pointed out the difficulties of interpreting the terms "total physical disability" and "constant and continuous care." The language of the statute and the limited state funds provided are a definite indication of the legislature's desire to "limit payment of aid to a very small group," he said.

The strict interpretation of the statute is a difficult administrative function requiring "complete objectivity and disregard of the strong emotional appeal which many of the cases present," Mr. Mannering stated.

J. W. Mannering.

The State Board of Public Welfare has ruled that "constant and continuous care" means that the major part of some person's time is required in attendance, and that aid is limited to persons whose disability is of a nature for which care and treatment are not available in state institutions.

The effect of these limitations is to disqualify the mentally deficient, the mentally ill, epileptics and any person with severe disability whose condition still being ambulatory cannot be considered one which requires constant and continuous care, he said.

Under the Wisconsin program, a fair hearing procedure is provided for cases involving controversy over eligibility. Questions of medical fact predominate, so that the state agency in most appeals reviews its own findings, Mr. Mannering said. This process results in a more thorough consideration of eligibility than otherwise possible.

While the program is limited in scope, he said, nearly 500 totally and permanently disabled persons receive aid from the plan. In September, 1948, this meant an expenditure of $31,678 or about $58.23 per recipient. The Wisconsin program is designed to aid the few who have special problems caused by degenerative diseases of the muscular skeletal and central nervous systems. "Within its limitations the program has achieved these aims," Mr. Mannering declared.

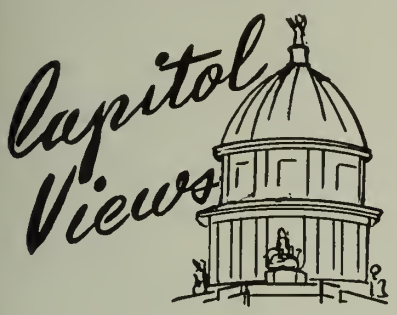
Prospects for expanding the program beyond its present limited scope hinge primarily upon the financial problems involved, he said. Legislators fear too rapid extension of such a program because even a limited expansion to include some mentally disabled and borderline physically disabled cases will increase the assistance payrolls from 500 to 2,000 cases. If the disability aid program is expanded to include all needy persons between 15 and 65 not in institutions but unemployable because of physical disability, the caseload may increase to 5,000 or 7,000 recipients, he said. Mr. Mannering stated that Wisconsin will probably not greatly extend its program, nor will other states adopt it, unless federal financial aid is forthcoming on a basis similar to the Social Security Act.

Propose National Prepay Plan for All Veterans

Washington, D. C., Oct. 25.—A proposal to provide prepayment medical and hospital care to all veterans through the Veterans Administration was advanced recently by American Hospital Association spokesman, before the Voorhees committee of the Hoover Commission currently engaged in investigations of the government's activities in the field of health.

Joseph Norby, Milwaukee, president, and George Bugbee, executive director, of the AHA recommended adoption of a plan to relieve the patient load on VA hospitals by providing medical and hospital care for veterans in their home communities on a prepayment basis. They said both service-connected and nonservice-connected disabilities would be eligible for this form of insurance.

Dr. Paul B. Magnuson, VA's chief medical director, has indicated opposition to the plan. The *Washington Report on the Medical Sciences* quotes him as saying, "The next step would be to blanket in their dependents and then you'd have socialized medicine."



The state unemployment compensation department is surveying 18,700 employers in Wisconsin to determine the types and amount of sickness, disability, time-loss and similar insurance programs being carried for their employees. So far 15,400 employers have replied. About 5,500 employers with 400,000 employees have some type of plan. Nearly 9,500 employers with 181,000 employees have no coverage.

* * *

The medical and hospital service of the United Mine Workers Welfare and Retirement fund is picking up speed. Seven doctors have been hired to take charge of area medical offices. Scope of program is seen in fact that this country has some 400,000 bituminous coal miners with some 1,200,000 dependents.

* * *

Answering criticism of modern radio problems, Editor William T. Evjue of *The Capital Times*, said recently, "The type of broadcasting you have today is the kind that's going to prevail under our free enterprise system. We have to have money to run these stations. The only alternative is government owned stations."

* * *

Since the national health service started in July, Surrey, England, druggists have dispensed more than half a million doctors' prescriptions for medicine and pills. This is two and a quarter times as many as in the same period last year.

* * *

The American Legion at its recent Miami convention took the following action: rejected a proposal to add chiropractors to VA staffs, opposed any "Federal socialized medicine program," and indorsed an undergraduate training program for nurses and technicians in VA hospitals.

UNIONS JOIN MOVE FOR CO-OP HEALTH

Plans Under Way in Rural and Urban Areas

Madison, Oct. 28—Campaigns for the establishment of cooperative hospital and health insurance programs are now underway in Racine, Kenosha and Polk Counties.

In Kenosha a drive to raise $125,000 for the building of a health center was started on October 4 by the Community Health Center Cooperative, Inc. A $10,000 loan from Local 72, UAW-CIO, a $500 loan by the AFL Milk Driver's Local 511 and pledges from several other unions opened the campaign.

The Kenosha Cooperative plans to sell individual memberships in the health center at $25 in addition to monthly dues of $3 for a single person, $5 per couple, $1 for the first dependent, and 50¢ each for the second and third dependents.

Complete Care

These rates are to entitle the person covered to complete medical and dental care and drugs, medical and dental supplies and appliances at reduced costs.

Literature put out by the Kenosha group states that those who purchase memberships during the first 60-day enrollment period will not be required to take a physical examination. However, excluded from coverage are pre-existing chronic conditions and "care not authorized by the medical director."

Racine Leaders Meet

The Racine 60 union leaders have met to discuss the organization of a Racine Cooperative Health Association some time in November. Leaders from unions and farm groups attended the meeting.

In Polk County a membership drive sponsored by the Polk-Burnett County Health Association began on October 15 and has produced about 125 members. Each member contributes $100 for the establishment of a hospital in Milltown.

Uphold New Jersey Medical Practice Act

Trenton, N. J., Oct. 1—Federal Judge Phillip Forman recently handed down an opinion sustaining the New Jersey Medical Practice Act.

In a decision of considerable importance to physicians as well as their patients, Judge Forman dismissed suits filed by the New Jersey Chiropractic Association and the New Jersey State Society of Naturopaths who argued that the Medical Practice Act violates the Fourteenth Amendment by abridging the rights of citizens to practice medicine.

They complained that the New Jersey statute restricted the treatment of the sick to physicians trained in medicine and surgery, thus conferring "an exclusive monopoly on medical and surgical practitioners," by restricting "care and treatment of New Jersey citizens to these forms of therapy."

They asserted that this law deprives citizens of New Jersey of the right to derive from chiropractic therapy the "benefits resulting from drugless and surgery-less treatment."

Judge Forman rendered a 20-page opinion upholding the existing statutes on all counts and confirming that the state has the right to decide who may or may not practice medicine.

BLUE CROSS—

(Continued from page 1)

that Associated Medical Care Plans request that the House of Delegates grant a hearing on the subject of these proposals; and that to implement this resolution the president of Associated Medical Care Plans be authorized to appoint a special committee of such size and personnel as he may determine effect ways and means for the ademine to develop and carry into quate presentation to the A.M.A. House of Delegates of all factors bearing upon this proposal."

Dr. C. O. Vingom, Chairman of the Directing Board of Wisconsin Physicians Service, introduced a resolution at the conference requesting that all Blue Shield Commissioners be physicians. At the present time lay directors of Blue Shield plans and physicians may be elected to these posts. Since the resolution requires a change in the Constitution and By-Laws, the matter will not be acted upon until the next annual conference.

PUBLIC RELATIONS IN PRACTICE

Spiritual Medicine . . . With a view to closer cooperation between doctors and ministers, 25 pastors of Rock county will send delegates to a meeting of the Rock County Medical Society. They will offer their help and cooperation in ministering to the sick. This promises to be good medicine for the ill and a good tonic for the doctor's public relations.

PR–PR–PR–PR

Health Roundup . . . Members of the Marathon County Medical Society were guests of the Health Council of Wausau to review the success of the city's first annual health roundup. One hundred seventeen children who entered school this fall for the first time received physical examinations from their family physicians.

PR–PR–PR–PR

Out in Front . . . The Brown–Door–Kewaunee County Medical Society is leading a movement for construction of a convalescent-type home for the chronically ill and aged in that region. Faced with ever-growing numbers of aged and chronically ill the Society realizes the need for an early answer to a problem that cannot ultimately be avoided.

PR–PR–PR–PR

No Time for Secrets . . . Medicine today is as much a social as it is a biological science, declares Dr. W. C. Rappleye, dean of Columbia University's faculty of medicine. The profession must "fully take the public into its confidence" and increasingly organize itself to participate in community efforts for the development of sound health and medical services."

PR–PR–PR–PR

An Ear for Good Public Relations . . . That Forest county became the first to actually put a hearing conservation program into operation was "chiefly due to the quick action of the Forest County Medical Society in accepting the program as outlined by the State Medical Society and the State Board of Health", states the Crandon *Republican*. The program is conducted in cooperation with Roger Maas, hearing consultant of the State Board of Health, the county nurse and local women helpers.

PR–PR–PR–PR

A Useful Idea . . . Advisors from business and industry in Waukesha sat down last month with high school seniors to discuss future training and job possibilities. They called it "Career Night." The Career Night idea, adapted to the professions of medicine, nursing and allied fields, would be a splendid demonstration of the cooperation possible between the medical profession and the public, as well as a positive move toward relieving the shortage of doctors and nurses.

A $400,000 Dream Come True . . . Arcadia, a town of 1,800 persons, has dreamed of a hospital for 35 years. Today they have it —a $400,000 seventy-one bed institution. The La Crosse *Tribune* said: "Much of the credit for its building goes to Dr. F. T. Weber, Arcadia, who convinced Bishop McGavick of La Crosse that a hospital in Arcadia would succeed." And a PR prize to you, Dr. Weber!

PR–PR–PR–PR

The Voice of Medicine . . . Dr. Paul B. Mason, Sheboygan, took time out from his practice to discuss rheumatic fever with his local Parent-Teacher Association recently. His contact with this organization is one of the many needed to bring parents and teachers reliable health information from those who know the answers.

PR–PR–PR–PR

Donation to Public Relations . . Both the profession and the public will benefit from a $10,000 donation by Dr. Robert L. Cowles, Green Bay, that will be divided between St. Mary's and St. Vincent Hospitals for their expansion programs. This is tangible evidence of the profession's interest in continued high caliber medical attention.

PR–PR–PR–PR

Protection Plus . . . Physicians in the Dodge, Marquette, Sauk, Oconto, Walworth and Rock county medical societies are continuing their leadership in public health movements by participating in city and rural immunization programs for children.

Surgeon's Education Costs Over $30,000

Rutherford, N. J., Oct. 13—Preparing for a career as a surgeon is one of the most costly professional undertakings in the United States today, according to a recent issue of *Medical Economics*, national business magazine for physicians.

A survey reveals that the average independent surgeon's higher education costs his family in excess of $30,000. This includes four years of college, four years of medical school, one year as an intern and four years of graduate surgical training.

In addition, the average surgeon's investment in equipment is $4,975. Dr. Henry A. Davidson, author of the article, states "for thirty-odd years the prospective surgeon is an expensive non-earning unit. His productive years are reduced at one end by a long and costly training period and at the other end by the possibility of coronary occlusion.

Invite GPs to St. Louis Session

Chicago, Nov. 3—The St. Louis AMA interim session, Nov. 30 to Dec. 3, "is a general practitioner's program from start to finish," declares Dr. George F. Lull, AMA general manager, as he extends an invitation to all physicians to attend.

He pointed out that the clinical sessions will be "basic" to give doctors the information they want —methods employed in diagnosing disease, treatment after diagnosis, exactly what and how much to prescribe and how often to administer the remedy.

Among the program highlights are the presentations on diabetes by E. P. Joslin, Boston; cancer, C. P. Rhoads, New York; jaundice, Sidney Portis, Chicago; hypertension, Irvine H. Page, Cleveland; obstetrical problems, Ralph Reis, Chicago; polio, Thomas Gucker, Boston; common skin diseases, Everett Fox, Dallas, and heart, G. R. Herrmann, Galveston.

An unusual feature of the session will be special entertainment on Wednesday, Dec. 1, starring Jimmy Durante, Bob Hawk, Red Foley and Vaughn Monroe's orchestra.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Dietary Treatment of Hepatic Cirrhosis

In April 1942, Dr. Arthur J. Patek through this page directed attention to the report by A. J. Patek, Jr. and J. Post[1] of benefit observed when patients with hepatic cirrhosis were fed a "highly nutritious diet supplemented with vitamin B concentrates." Subsequent studies have amply confirmed their original thesis but so far have failed to establish definitively relative values for individual dietary components.

Chiefly by analogy with animal experiments, protein has come to be considered of paramount importance. A frequent recommendation is to allot 120 to 175 Gm. of protein per day, with the remainder of a diet of 3,000 to 3,600 calories divided between carbohydrates and fats, the balance slightly favoring carbohydrate. An early trend toward extremely low fat diets has generally been abandoned because of their unpalatability and because of failure to demonstrate that moderate amounts of fat are detrimental when they do not replace other components.

Patek and Post employed thiamine chloride, parenteral liver extract, and large doses of brewer's yeast as adjuncts to their diet. Most reports since have included the use of these or similar preparations with no analysis of their individual importance. Beams and Endicott,[2] in a small series of similarly treated patients, found histologic improvement only in those patients receiving an additional 4 to 5 Gm. of methionine daily. Labby *et al.*[3] have reported greatly increased benefits following large doses of a crude water-soluble liver extract intravenously. P. György[4] has pointed out that in the treatment of pre-existing experimental cirrhosis, a combination of methionine and oral crude liver extract was superior to any other dietary supplement evaluated. The only large series in which dietary treatment did not favorably influence mortality rates failed to employ yeast, B complex supplements, or liver extract. Three to 5 Gm. of choline daily and one quart of skim milk, providing approximately 0.9 Gm. of methionine daily, were used.[5]

Layne and Schemm[6] emphasize a different aspect of the problem in a report of excellent control of ascites with a neutral ash, low sodium, high carbohydrate diet, aided by a 4,000 to 5,000 cc. fluid intake, 4 Gm. of ammonium chloride daily, and at times mercurial diuretics, vitamin supplements, and intramuscular liver extract. Combination of the neutral ash, very low sodium content of their schedule with a high protein intake makes for a rigid, somewhat unpalatable program, probably worthwhile only if the patient will adhere to it without unduly reducing total food acceptance. More commonly it will prove practical to restrict only the sodium without enforcing the neutral ash requirement.

The excellent results following intravenous serum albumen, as reported by Kunkel and associates,[7] should be mentioned, since they are in a sense dietary. Not only was there disappearance of ascites in most instances, but "A rise in calorie intake and increased retention of dietary nitrogen were demonstrated . . . where the response could not be attributed to relief from the disabling effects of fluid." Should this material become generally and economically available, it may well represent an invaluable aid. With presently available preparations, the similar use of whole plasma can, in most instances, only be condemned, because of the possibility of superimposing serum hepatitis on the already damaged liver.

In the light of the experiences cited above and current availability of therapeutic agents, it would seem best to place cirrhotic patients wherever possible on a diet of 3,000 to 3,600 calories daily, allotting 120 to 160 Gm. to protein, 300 to 375 to carbohydrate, and the balance to fat. Large doses of a relatively complete vitamin B complex preparation may replace the yeast (which often produces gastrointestinal discomfort), and where fluid retention is a problem, sodium intake should be sharply restricted. Alcohol is generally interdicted. Water is not restricted, and on occasion may be forced. Animal experiments and fragmentary clinical data tentatively seem to justify oral administration of 4 to 6 Gm. of methionine daily and 3 to 6 cc. of crude liver extract intramuscularly two or three times weekly. All other available aids, such as bed rest, diuretics, antibiotics, and "acidifying salts," should be employed where the indication arises.

Anorexia, various gastrointestinal symptoms, and lack of cooperation on the part of the patient frequently frustrate dietary programs. Careful attention to the patient's tastes and culinary ingenuity may circumvent some of these difficulties. Time should be spent in explaining to the patient the nature of his illness and the importance of diet. A liquid diet plus protein digests prescribed as "medicine" will often be accepted where ordinary foods are not. In patients unable to take food by mouth, large amounts of glucose and protein hydrolysates intravenously are occasionally followed by striking improvement and resumption of oral ingestion of food.

Most workers agree that improvement in appetite and general sense of well-being may be a very important part of the effects of supplemental dietary agents. Patek further points out that ascitic fluid

(Continued on page 1132)

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and
S. B. PESSIN, M. D., Marquette University, Milwaukee

E. A. BIRGE, II

Doctor Birge, who is now director of the laboratory at Milwaukee Hospital, received his medical degree from Johns Hopkins University School of Medicine in 1936. In 1938 he joined the staff of the University of Wisconsin Medical School as an instructor in clinical pathology. Following service with the Army Medical Corps from 1942 to 1945, he returned to the staff of the university as assistant professor of clinical pathology. He has served in his present position since early in 1947.

The Laboratory Diagnosis of Amebiasis

Amebiasis is endemic in the United States, having been found in all states of the union, and its diagnosis is a problem which continually recurs in the laboratory. The disease, however, is not as prevalent as the average clinician believes. Figures given by textbooks generally say that the incidence in the United States as a whole is 10 per cent of the general population. When one examines the statistics more closely, one finds that the figures given are usually those from surveys done in the southern states. Boeck and Stiles in 1923 reported an incidence of 4.1 per cent for the general population of the United States. Faust and Headlee reported an incidence of 8.3 per cent in Louisiana, while Meleney and his co-workers reported an incidence of 11.4 per cent in Tennessee. All of these figures are much higher than one sees in Wisconsin. In the opinion of the writer, based on his observations over the last ten years, the incidence of amebiasis in Wisconsin probably does not exceed 1 to 2 per cent of the general population. In line with this opinion, Snorf and his co-workers reported a 2 per cent incidence of amebiasis in an asymptomatic group of patients admitted to the Evanston Hospital, while 4.3 per cent of patients with intestinal symptoms were found to harbor the parasite. Lack of knowledge of the frequency of the disease in this state has often led to considerable confusion between the clinician and the laboratory, the clinician feeling that the laboratory has not adequately examined the specimens which he has submitted.

In collecting the specimen, one should bear in mind the fact that the ameba occurs in both the trophozoite and the cystic form. The trophozoite is found only in patients who have an active diarrhea, and it is useless to search for it in individuals who are passing formed stools. In patients whose stools are liquid or semisolid an examination for trophozoites should always be done. Stools of this type should be collected in a warm bed pan and a portion transferred to a container, which is kept warm until it can be examined. If the patient is not in the hospital, the stool should be passed at the laboratory. Once the stool has cooled, the trophozoite tends to round up into the precystic form. In this form it is extremely difficult to recognize. If the patient is passing only solid, formed stools, then there is no necessity to keep the specimen warm. In the formed stool the ameba occurs only in the cystic form which is extremely resistant to environmental changes. Therefore, the specimen may be passed at home and kept in the icebox until it can be examined.

For the demonstration of cystic forms the specimen must always be examined by one of the concentration methods. The author prefers the zinc-sulfate flotation method. Examination of the specimen by simple smear or even by centrifugation of a small portion of the specimen is not satisfactory. In general, a minimum of three consecutive specimens should be examined in all cases of suspected amebiasis. Many authorities recommend that a minimum of six specimens be examined. Examination of a single specimen is very apt to be misleading. When three specimens are utilized, the first two should be normal stool specimens passed in the usual manner. The third specimen should be obtained after the patient has been given a saline purgative. This last specimen should be examined for both trophozoites and cysts. Occasionally material from a proctoscopic examination is submitted. When a proctoscopic examination is done, material should be collected from the suspected ulcers, using a small cotton swab which has been moistened slightly with sterile peptone broth. Saline should not be used, since there is evidence to show that saline is often toxic to the ameba and causes it to assume the precystic form. Such specimens should be sent immediately to the laboratory.

Inexperienced workers should not make a diagnosis of amebic trophozoites unless they actually see motile forms in the smear. Amebae are most apt to be confused with large macrophages. Macrophages do not have the motility of amebae and, if one bears this simple rule in mind, confusion is much less apt to occur.—EDWARD A. BIRGE, M. D.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

V. F. OTIS

Vincent F. Otis joined the State Board of Health in July 1945, following four war years of administrative duties in the field of hospital administration at the Milwaukee County Institutions, Wauwatosa. He directed the recent state-wide hospital survey. Last month in Atlantic City, N. J., he was elected a member of the Interim Executive Committee to form a voluntary organization of hospital planning agencies throughout the country.

General Hospitals For Rural Physicians

A state-wide survey of existing hospital facilities completed in December 1946 disclosed that six Wisconsin counties, comprising a total of 4,324 square miles with a total population of 61,375, of which 94.4 per cent is rural, were without hospital facilities of any type. Another ten counties, with a total population of 166,718, of which 94.3 per cent is rural, had one hospital, each under 25 beds in size. The survey indicated that forty-eight general hospital service areas, primarily rural, had approximately one-third of the needed hospital beds, whereas twenty-three urban areas, containing small portions of rural population and in many instances serving many of the forty-eight rural areas, contained two-thirds of the beds needed to adequately serve patients seeking hospital care. Is it surprising, then, to find reluctance on the part of physicians in establishing themselves in areas of the state lacking hospital facilities when the modern physician is trained to practice in a hospital? Obviously, there are other economic and social factors which also influence a young doctor's choice of communities, but very frequently the availability of a modern general hospital is a deciding factor.

Rural Outlook Brightens

Public Law 725, The Federal Hospital Survey and Construction Act (Hill–Burton Bill supported by the American Medical Association), provides a limited amount of federal grants-in-aid, on the basis of one federal dollar for every two local dollars, to assist in the construction of hospitals in areas having the greatest need, giving special consideration to rural areas and areas with low financial resources. Already during 1948, your Board of Health approved eleven general hospital projects in small communities of the state, averaging 35 beds per project, which will serve a total rural population of 202,438 inhabitants. All of the projects approved from funds available for general hospital beds during the first two fiscal years are to be constructed in areas having from 0 to 25 per cent of the needed hospital beds. Eight of these communities—Tomah, New Richmond, Fort Atkinson, Viroqua, Clintonville, Platteville, Osceola, and Boscobel—upon completion of construction will have a modern fire-resistive hospital for the first time. Except for Tomah, where a general hospital does not exist, these communities have been operating with temporary facilities, using old residences or commercial buildings converted to hospital use. The remaining three projects—at Menomonie, Dodgeville, and Burlington—are additions to existing structures, originally constructed as hospitals. Thus, the doctors already established in these eleven general service areas of the state can look forward to the practice of medicine in the modern way and perhaps attract younger physicians and surgeons to settle in the communities. Since the program does not expire until June 30, 1952, further opportunities will be available for eligible communities to provide the much needed facilities in other rural areas of the state. Unfortunately, some of the areas with urgent needs are finding it difficult to raise the funds required to meet the rising construction costs, even where federal aid takes care of approximately one-third of the total project costs.

Rural Hospitals and Statewide Service

While it is desirable to establish small modern hospital facilities for physicians and surgeons serving rural areas, economy of operation and maintenance is difficult and can best be accomplished through integration with larger hospitals and medical schools. Such integration involves: (*a*) planning the location and size of rural hospitals in order to avoid unnecessary duplication of facilities; (*b*) establishing consultation services for the administration of rural hospitals from the administrators of larger general hospitals in order to maintain the high level of administrative control of the business phases of hospital operations and effective administration of the professional and technical phases of hospital services; (*c*) interchanging service and pooling of equipment among hospitals, where possible, in order to reduce the cost of hospital operation; (*d*) integrating some services and departments which the smaller hospital cannot support on a full-time basis alone, i.e., pathology, radiology, accounting, purchasing, dietetics; and (*e*) cooperating in making the maximum use of all hospital facilities during periods of high demand for service, especially in the case of small hospitals which are not as flexible and find it difficult to maintain a high rate of occupancy. The future, indeed, looks much brighter for the rural physician.—VINCENT F. OTIS, *Director, Division of Hospital Survey and Construction.*

As Seen From the Countryside

M. K. SWANTON

As a farmer and as executive secretary of the Wisconsin Council of Agriculture Cooperative, Milo K. Swanton's interests and efforts have been in the realm of rural life and agriculture. He served as chairman of the Rural Health Survey Committee of the National Milk Producers' Federation. He is vice-president of the American Country Life Association, trustee of the American Institute of Cooperation, and a director of the National Milk Prodneers' Federation.

OUR farm house was "the end of the line" when I was a boy. Night or day, my parents responded to such requests as "Hi, phone old Dr. Harper quick; the woman can't hold out 'til mornin'." Within an hour we'd hear the clatter of horses' hoofs and the rattle of Doc's buggy wheels whirring to relieve the worries of some expectant father, to bind up the wounds of a farm accident, or ease the last hours of an old neighbor and friend. That is a glimpse of rural medical service in the days of old.

Today the telephone lines are more extended. Good roads and autos have shortened the lines of medical service. And the medical practice has outgrown the limitations of the "little black bag." These improvements, coupled with the failure of the doctor supply to keep pace with growing city needs, have caused physicians to seek more satisfactory fields in the larger centers of population.

Yet, rural Wisconsin has better service than it had fifty years ago, thanks to scientific advancements, better technics, and improved equipment which have boosted the quality of service and have made the individual doctor more efficient.

In 1862, included in the first annual report of the United States Department of Agriculture, we find, "The impression is that farming is the most healthful life, but *we must look the whole facts in the face.*" Eighty years later, we looked "the whole facts in the face" as we studied selective service medical reports disclosing a serious health difference between country and city.

Although disease knows no city-country boundary line, yet there are many lines of difference. Sanitation and safe water supplies can be more of a problem in the country. Long hours of work exposure, child labor sometimes in excess, generally low net incomes, and lack of health supervision in the one room rural school may help to account for the unfortunate difference.

Every doctor and dentist who serves rural people knows that today's diverse modern and mechanized farming is one of the most dangerous occupations in America. All this tells the need for more medical service in the country. Yet the availability of doctors is getting worse.

The city-country disparity was aggravated by World War II. Only 1 per cent of medical officers indicated their intention to set up practice in communities of under 2,500 people, and only 20 per cent chose towns of 2,500 to 25,000. Among dental officers the poll showed that 9.6 per cent planned to hang out their shingles in communities of under 5,000.

Today the very same Wisconsin farm people who, with 11 per cent less manpower produced 41 per cent more food during the war than they had ever produced before, are asking why the "production" of medical personnel has failed to keep step with increased population and higher per capita demand. Is it because medical colleges lack sufficient equipment and facilities? Certainly there is a public responsibility and individual responsibility as taxpayers to expand educational opportunities for the training of more men in the medical and dental professions.

Whether justified or not, there is a growing public feeling that the medical profession has been too much concerned about an overcrowded profession. I doubt if there ever has been a real surplus in the supply of qualified physicians in relation to human needs.

Perhaps it is because the tempo of modern life has resulted in greater loss of health and added fears, it may be the spread of medical and hospital insurance plans, it may be caused by social reform movements that have played upon the suspicions and fears of the American people; at any rate, whatever the reasons may be, the medical profession is today under the microscope of public opinion.

It was Bobby Burns, the great Scotch poet, who so ably expressed the need for self appraisal. In church he saw a louse on a lady's hat, then penned those famous words:

Oh wad some power
The giftie gie us
To see oursels
As others see us.

Rural Wisconsin is deeply interested, and I know the medical profession is deeply concerned. Rural Wisconsin's growing health needs, the increasing city-country disparity, and the general shortage of doctors spell the need for joint responsibility between practitioner and citizen. It demands teamwork and appraisal. It is time "to look the whole facts in the fact."—MILO K. SWANTON, *Executive Secretary, Wisconsin Council of Agricultural Cooperatives.*

. . . . THE PRESIDENT'S PAGE . . .

Convalescent Homes For Acute Rheumatic Fever Victims

THE attention of the nation in the last few years is being focused on heart disease largely because it ranks with cancer as one of the greatest killers. Efforts at prevention in the senior years of life are not particularly fruitful. In recent years the people are beginning to pay greater attention to one of the parent diseases, namely, acute rheumatic fever. Recognition of the need for convalescent homes is becoming greater as the benefit derived by victims of acute rheumatic fever in these homes is gradually being brought home to physicians and the public alike.

A striking parallel can be drawn between acute rheumatic fever and tuberculosis. In each we know the etiology, pathology, and treatment. Each may have an insidious onset. Each requires a long period of convalescence. Sanitarium care has reduced the death rate from tuberculosis from a major position to a relatively minor one. Fear does not keep the patient away from the physician, and, as parents become more familiar with the symptoms of acute rheumatic fever, so will they become more mindful of the benefits of convalescent home therapy.

The cancer program has yielded large sums of money for diagnosis and research but does not require large sums for prolonged convalescent therapy. The cancer foundation coffers are bulging at the seams.

The infantile paralysis foundation by popular appeal has acquired large sums of money for research and therapy. Our state and county hospitals are equipped to treat adequately those patients who survive and require long convalescent management.

The public must be made to realize that in children the incidence of rheumatic fever is ten times greater than in poliomyelitis; the probability of being crippled is more than twice as great, the chances of death four times greater, and the prospect of full recovery is one-half in acute rheumatic fever as contrasted to poliomyelitis.

Our great nation is composed of the most generous people on earth, and their enthusiastic response is inevitable when their sympathy and understanding are aroused.

This response must be aroused through education, popular appeal by press and radio, and fund drives. This is the season of the year when Community Chest fund drives are under way, and homes for patients with acute rheumatic fever should receive a portion of these funds.

We have turned the trick to tuberculosis, cancer, and poliomyelitis. Why not for acute rheumatic fever.

Karl Davis.

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Introducing the Guest Editorialist

As a matter of fact, Professor Conrad Arnold Elvehjem needs no introduction to the physicians of Wisconsin because his work has played such a significant role in the practice of each of these physicians. Probably Conrad Elvehjem is best known for his contributions to the study of the vitamin B complex. Incidentally, he is a native son of this state, having started his life in McFarland, near Madison, on May 27, 1901. Later he attended the University of Wisconsin, where he was granted the B. S. degree in 1923 and the Ph. D. degree in 1927. He spent 1929–1930 at Cambridge University in England, returning to his native state and university, where he has taught biochemistry in the College of Agriculture. He had full professorial rank in 1936 and was made departmental chairman in 1945. A year later Doctor Elvehjem was selected as dean of the graduate school of the University of Wisconsin, which position he continues to hold.

He is married and has two children.

Doctor Elvehjem holds the Sc. D. degree granted by Ripon along with multiple honors, memberships in learned societies, awards, and medals. He is a member of the food and nutrition group of the National Research Council and is associated with the Virus Research Committee of the National Foundation for Infantile Paralysis.

He has contributed extensively to the scientific literature and particularly on the subject of vitamins and nutrition, which all adds up to tell you that he is thoroughly qualified to present his views on animal experiments with which he is so familiar, but you must read his story to convince yourself.—L. R. COLE.

Vivisection and Research

ANIMAL experimentation is usually discussed in terms of heroic contributions to the advancement of medical science. This is understandable. Impressive facts are proof positive of the claims for the value of vivisection as opposed to the pseudo-sympathy which fires the opposition of the antivivisectionists.

But I would advance a more subtle argument; animal experimentation has made it possible to inquire into *every* minute function of the human body, both in health and disease, so that man may eventually arrive at an absolute understanding of his own requirements and limitations. The results of inquiry into divergent facets of the same problem make up the sum total of our comprehension. The pooled resources of our minds as expressed in our professional journals are the true measure of our intellectual growth. Each verification of a supposition, every improvement in technic, any significant addition to our collective body of skills gleaned from animal research, is salient proof of the necessity for vivisection.

To take a field in which I am thoroughly at home, the biochemist studies the qualitative and quantitative nutritional needs of all living organisms, from man through the lesser animals, down to plants and micro-organisms. He learns to comprehend the changes occurring within the cell. With the recognition of the end products of cellular activity he is able to distinguish between toxic substances that need to be discarded and products which have medicinal or industrial value.

Although the initial training of a student involves theory and the mastery of laboratory technic, it is through original experimentation with "living tissue" that he is able to make his own significant contribution to the stock-pile of information from which all may draw. Laboratory work with animals must continue unhampered, not primarily because of isolated achievements which have resulted from such study, but because unrestricted animal experimentation is the fertile soil from which future advances in medicine must draw their strength. As a case in point, the background for the discovery of vitamins reveals the fact that early experiments disclosed unknown factors needed for optimum nutrition. Not until animal experimentation was employed could these factors be measured. The entire field of vitamin investigation is rooted in this initial study, and therefore the preparatory work which precedes the isolation of a specific vitamin becomes a more potent argument for the support of animal experimentation than the more spectacular discovery of the vitamin itself.

Without the privilege of animal experimentation—or with a grudging sanction hedged about with nullifying restrictions—America's investigators and educators may as well lock their laboratories and let the dust becloud their microscopes. Unless there is continued opportunity for animal experimentation, these highly trained men and women must content themselves with an unproductive review of work already accomplished; their students will have the dubious privilege of advancing only so far as theoretic investigation will allow. If the lobbying of the antivivisectionists succeeds in throttling scientific investigation, then both factions are at fault. We may rightly blame the antivivisectionists for knowingly or unwittingly halting the progress which they have already undermined. But members of the professions most vitally concerned who do nothing, either collectively or as individuals, to halt these vicious activities, must of necessity share in the guilt.

Conrad A. Elvehjem

SOCIETY PROCEEDINGS

Barron—Washburn—Sawyer—Burnett

Two physicians from the Duluth Clinic at Duluth, Minn., were guest speakers at the October meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society, which was held at the Land O'Lakes Hotel in Rice Lake on October 19. They were Drs. F. J. Hirschboeck and H. G. Moehring, who presented cases with x-ray interpretations. *Dr. R. G. Arveson* of Frederic informally discussed activities in the field of health insurance.

Brown—Kewaunee—Door

Members of the Brown–Kewaunee–Door County Medical Society met for a dinner meeting at the Beaumont Hotel in Green Bay on October 14. The delegates of the Society reported on the proceedings of the House of Delegates of the State Medical Society in Milwaukee.

Dodge

A. A. SCHAEFER

Dr. William Costello of Beaver Dam was named president of the Dodge County Medical Society at its meeting at St. Joseph's Hospital, Beaver Dam, on September 23. Other officers elected were vice-president, *Dr. E. C. Hoyer;* secretary, *Dr. A. B. Kores;* delegate, Doctor Costello; alternate delegates, Doctor Kores; and censor, *Dr. A. W. Hammond,* all of Beaver Dam. Guest speaker at the meeting was *Dr. A. A. Schaefer* of Milwaukee, who discussed "Pediatric Surgery."

Eau Claire—Dunn—Pepin

Members of the Eau Claire–Dunn–Pepin County Medical Society heard two Milwaukee physicians speak at their meeting on October 25, held at the Elks Club in Eau Claire. *Dr. George Jurgens* presented a paper on "Cystic Disease of the Lung," and *Dr. Mischa Lustok* spoke on "Carcinoma of the Lung."

Fond du Lac

Election of officers was held at the September 23 meeting of the Fond du Lac County Medical Society, held at the Hotel Retlaw in Fond du Lac. *Dr. W. C. Finn* was named president; *Dr. J. S. Huebner,* vice-president; and *Dr. F. J. Cerny,* secretary–treasurer. All those named to positions are from Fond du Lac.

Kenosha

Holding their October dinner meeting at the Elks Club on October 7, members of the Kenosha County Medical Society heard a talk by Dr. A. C. Ivy, professor of physiology at the University of Illinois College of Medicine. Doctor Ivy, who is vice-president of the University of Illinois in charge of the schools of medicine, dentistry, pharmacy, and nursing, and head of the university department of clinical science, discussed the subject "Psychosomatic Aspects of Etiology and the Treatment of Peptic Ulcer."

Outagamie

Election of officers was held at the meeting of the Outagamie County Medical Society at the Riverview Sanitarium in Little Chute on October 21. *Dr. G. M. LaCroix,* Shiocton, was named president *Dr. S. A. Konz,* Appleton, vice-president; *Dr. Robert D. DeCock,* Appleton, secretary; *Dr. E. F. McGrath,* Appleton, censor; *Dr. G. W. Carlson,* Appleton, delegate; and *Dr. George Boyd,* Kaukauna, alternate delegate. A discussion of the "Types of Onset of Pulmonary Tuberculosis" was presented by *Dr. J. G. Russo,* superintendent of Riverview Sanitarium, and *Dr. G. W. Carlson* reported on the proceedings of House of Delegates of the State Medical Society during its Annual Meeting.

Shawano

Discussions by two members of the staff of the University of Wisconsin Medical School were presented at the first meeting of the season of the Shawano County Medical Society. The session was held at Gumaer's Resort in Shawano on September 21. The speakers were *Dr. Joseph Gale,* professor of surgery, and *Dr. Llewellyn R. Cole,* coordinator of graduate medical education. Doctor Gale discussed "Surgery of the Lungs" and Doctor Cole spoke on the postgraduate courses being offered this year at the university medical school.

Washington—Ozaukee

"Heart Disease in Pregnancy" was the subject of a paper presented by *Dr. H. L. Correll* of Milwaukee at the September meeting of the Washington-Ozaukee County Medical Society. The session was held at the Cedars in Cedarburg on September 23.

Winnebago

Members of the Winnebago County Medical Society gathered at the Hotel Menasha in Menasha on October 14 to hear a discussion on "The Mechanism of Edema and Water Balance" by *Dr. K. L. Puestow* of Madison. Doctor Puestow serves as professor

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of clinical medicine at the University of Wisconsin Medical School. At the meeting a report on the actions of the House of Delegates of the State Medical Society was given by *Dr. Byron J. Hughes*, delegate from Winnebago County.

Section on Pediatrics

The Section on Pediatrics of the State Medical Society was formally organized at the Annual Meeting of the State Medical Society on October 6. The following officers were elected: chairman and delegate, *Dr. M. G. Peterman*, Milwaukee; vice-chairman, *Dr. J. E. Gonce, Jr.*, Madison; and secretary, *Dr. F. J. Mellencamp*, Milwaukee.

State Chapter of American Academy of General Practice

The first meeting of the state chapter of the American Academy of General Practice, which was organized in June, was held at the Hotel Menasha in Menasha on October 7. *Dr. J. P. Canavan*, Neenah was elected president; *Dr. George E. Forkin*, Menasha, president-elect; and *Dr. W. B. Hildebrand*, Menasha, secretary-treasurer. The credentials committee consists of *Dr. W. B. Hildebrand*, chairman; *Dr. T. D. Smith; Dr. Paul T. O'Brien;* and *Dr. G. N. Pratt.*

News Items and Personals

Three La Crosse Physicians to Staff Grandview Clinic

Three La Crosse physicians—*Drs. Paul D. Anderson, John J. Satory,* and *Robert L. Gilbert*—will serve on the staff of the Grandview Clinic, recently organized in La Crosse.

Doctor Anderson, who will practice general medicine and obstetrics, is a graduate of Marquette University School of Medicine. Following a period of service in the Army Medical Corps, he took postgraduate studies in Cleveland before opening his practice in La Crosse in 1946.

The surgeon on the staff, Doctor Satory, received his degree in medicine from the University of Minnesota Medical School. For a time he was an instructor in surgery at Marquette University School of Medicine. Certified by the American Board of Surgery, he also established his practice in La Crosse in 1946.

Doctor Gilbert, a specialist in internal medicine, graduated from Yale University School of Medicine. Following three years of Army service in the European theater, he took postgraduate work in medicine at St. Louis City Hospital, St. Louis, Mo. He located in La Crosse last April.

Dr. C. P. Kauth Appointed County Physician

Dr. C. P. Kauth, Port Washington, was appointed county physician by the chairman of the Ozaukee County Board to fill the unexpired term of *Dr. W. H. Drissen*, who died on September 10. The present appointment expires on January 1, 1949.

Dr. B. F. Palmer Establishes Bayfield Practice

Dr. B. F. Palmer, who recently moved to Three Lakes after thirty-three years of practice in Milwaukee, has now located in Bayfield. The doctor, a graduate of Marquette University School of Medicine, will limit his work to medical practice and diagnosis.

Vernon Memorial Hospital Staff Organizes

Dr. Lars F. Gulbrandsen, Viroqua, was elected president of the Vernon Memorial Hospital staff at an organization meeting held in Viroqua on October 12. Other officers of the staff, which will aid in improvement of the medical services at the Viroqua Hospital and plan the facilities for the new hospital scheduled for construction next spring, are *Drs. R. S. Hirsch*, Viroqua, vice-president, and *C. M. Strand*, Westby, secretary.

Monument Dedicated to Dr. G. E. MacKinnon

Friends of the late *Dr. G. E. MacKinnon* of Prentice gathered at the cemetery in Prentice on October 17 for the dedication of a monument to "The County Doctor" who served that community for more than thirty years. The memorial was purchased with donations from the people of Prentice, many of whom he had cared for without charge. It is inscribed with a horse and buggy with its occupant and bears the words "The Country Doctor."

Alma Honors Doctor For Half Century of Service

Over 400 people wearing badges stating "I'm a Dr. Tenney Baby" were present at "Dr. Tenney Day" on September 17 in Alma to honor a physician who has served that community for fifty-two years —Dr. J. S. Tenney. The celebration was part of the fall festival sponsored by the American Legion and the Chamber of Commerce, which also commemorated the Wisconsin Centennial.

A public reception was held during the afternoon, and a testimonial dinner followed, at which *Dr. M. O. Bachhuber*, Alma, was master of ceremonies. At the close of the afternoon program the doctor was presented with over a thousand cards bearing messages from those whom he brought into the world.

The doctor received his degree in medicine from the University of Minnesota Medical School in 1895 and located in Alma shortly afterward.

Dr. S. E. Gavin to Head State Board of Health

Dr. S. E. Gavin of Fond du Lac was recently named president of the State Board of Health, to succeed *Dr. Ira F. Thompson*, Beloit. Doctor Thomp-

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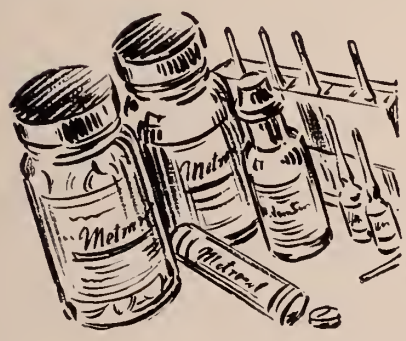

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son, who resigned from the presidency because of ill health, will remain on the board. At a meeting on October 1, the board elected *Dr. S. L. Henke*, Eau Claire, vice-president to succeed Doctor Gavin.

Dr. C. E. Kozarek Opens Own Practice

Dr. C. E. Kozarek, Tomah, who has been associated with *Dr. James Fraser* in that community for the past year and a half has withdrawn from the partnership and set up a private office practice. Prior to his association with Doctor Fraser in Tomah, he served in the Army Medical Corps.

Dr. K. F. Pelant Opens Practice in Grafton

Dr. Kenneth F. Pelant, who has been on the staff of the Brillion Clinic since his discharge from service, opened a practice in Grafton late in September. Doctor Pelant, a graduate of Marquette University School of Medicine, was also associated with the Brillion Clinic before his entrance in the Army Medical Corps.

Minnesota Dermatologic Society Meets in Marshfield

Forty-three skin specialists from four states attended the summer meeting of the Minnesota Dermatologic Society held at the Marshfield Clinic in Marshfield on September 18. The clinical meeting had been prepared by *Drs. Warren L. Macaulay* and William O'Connor from the staff of the Marshfield Clinic. The following members of the staff presented and discussed cases: *Drs. Stephan Epstein, W. L. Macaulay*, William O'Connor, *J. M. Wickham, R. S. Baldwin*, and *John B. Miale.*

In the evening the visiting physicians had dinner at the Hotel Charles.

Guest of honor at the meeting was Dr. John C. Belisario, professor of dermatology from Sidney, Australia, who was introduced by Dr. Frederic T. Becker, president of the Minnesota Dermatologic Society.

Dr. A. T. Nadeau Honored By Knights of Columbus

A. T. NADEAU

Special tribute was paid to *Dr. A. T. Nadeau* of Marinette by the Knights of Columbus of that community at their Landing Day banquet on October 13. Doctor Nadeau, who has been a physician in Marinette for forty-six years, was presented with a plaque of the resolution passed by the council of the organization. A duplicate plaque will be placed in the club rooms. Doctor Nadeau was a member of the second class initiated into the group after organization of the council in 1902.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

THIRD DISTRICT NEWS

Dr. F. E. Mohs Reports on Cancer of the Skin in Journal of the American Medical Association

The report of a 93.6 per cent rate of cure in cancer of the skin by *Dr. Frederic E. Mohs*, Madison, was published in the October 23 issue of the *Journal of the American Medical Association.* Doctor Mohs, assistant professor of surgery at the University of Wisconsin Medical School, pioneered the development of chemosurgery, a technic utilizing chemistry, surgery, and the microscope, in treatment of cancer. Physicians using this method can make sure that cancers are entirely removed, because the technic is controlled microscopically. Doctor Mohs pointed out that "The method is useful in the treatment of a number of other accessible forms of cancer besides cancer of the skin and is applicable to the treatment of certain noncancerous conditions. Therefore, it would seem to be justifiable to recommend the establishment of chemosurgical clinics in each large center of population."

Harvard Medical Man Lectures At University Medical School

Professor George Wald of the Biological Laboratory at Harvard University spoke at an open public lecture at the University of Wisconsin Medical School on October 26. His subject was "Human Vision and the Spectrum." Professor Wald is an

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Frank W. Mackoy, M. D. — George W. Dean, M. D.
J. Frampton Wyman, M. D. — Owen C. Clark, M. D.
Hubert H. Blanchard, M. D. — John E. Leach, M. D.
George F. Meisinger, M. D.

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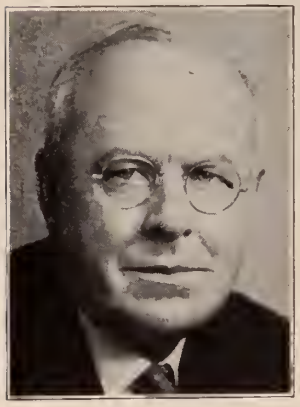
outstanding authority on the subject of vision, and he has made a number of valuable contributions to the knowledge of this subject. The relation of vision to vitamin A and the chemistry of the retinal pigments have been among his publications. In 1939 he received the Eli Lilly award.

Dr. A. L. Tatum Receives Honorary Degree



A. L. TATUM

The highest degree awarded by the Greater University of San Marcos, in Lima, Peru, the Doctor Honoris Causa, was bestowed on *Dr. A. L. Tatum*, Madison, when he visited that institution on September 27. A gold medal was also presented to the doctor, who is professor of pharmacology at the University of Wisconsin Medical School, for his work in the field of pharmacology. While in Lima, Doctor Tatum lectured at the medical school of the university on his personal experiences in research investigation.

Following their visit to Peru, Doctor and Mrs. Tatum traveled to Guatemala. They returned to Madison late in October.

Dr. E. P. Joslin Gives Loevenhart Memorial Lecture

The third annual Arthur S. Loevenhart memorial lecture was presented by Dr. Elliott P. Joslin of Boston at the University of Wisconsin Medical School of November 10. The subject of the lecture was "Observations on Diabetes Mellitus." Doctor Joslin, professor emeritus of medicine at Harvard Medical School, is internationally known for his distinguished work in diabetes. The address was sponsored by the Wisconsin chapter of Phi Delta Epsilon, medical fraternity, which has presented this memorial lecture annually.

Dr. J. T. Syverton Lectures At University Medical School

Discussing the subject "Interference Phenomena in Viral Infections," Dr. Jerome T. Syverton, Minneapolis, lectured at the Service Memorial Institutes Building of the University of Wisconsin Medical School on October 25. Doctor Syverton is professor of bacteriology and immunology at the University of Minnesota Medical School.

SOCIETY PROCEEDING

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society heard a report on the International Congress on Mental Health by *Dr. Gilbert J. Rich*, Milwaukee, at their October meeting. The group met at the University Club in Milwaukee on October 20.

Milwaukee Surgical Society

W. G. MADDOCK

Dr. Walter G. Maddock, a member of the staff of Northwestern University Medical School, was the guest speaker at the October meeting of the Milwaukee Surgical Society, held October 4 at the University Club in Milwaukee. Doctor Maddock presented a paper entitled "The Mechanism of Abdominal Distention."

Milwaukee Academy of Medicine

"Changing Concepts of Protein Nutrition" was the subject of an address by Dr. Paul R. Cannon, Chicago, at a meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee on October 19. Doctor Cannon is chairman of the department of pathology at the University of Chicago School of Medicine.

SOCIETY RECORDS

New Members

Ward E. Brown, 527 Grove Street, Waukesha.

Hubert S. Houston, 912 Beechwood Avenue, Waukesha.

W. Graham Cameron, 131 South Barstow Street, Eau Claire.

William D. Battle, 1300 University Avenue, Madison.

Dean B. Becker, Jr., 1300 University Avenue, Madison.

George C. Hank, 122 West Washington Avenue, Madison.

Edna M. J. Fitch, 1300 University Avenue, Madison.

John C. Moore, 113 North Carroll Street, Madison.

Robert A. Straughn, 16 South Carroll Street, Madison.

Sion C. Rogers, 110 East Main Street, Madison.

Dayton H. Hinke, 118 West Mills Street, Richland Center.

Vernon J. Burch, 2731 Washington Avenue, Racine.

Bernard S. Marsho, 906 North Eighth Street, Sheboygan.

James S. Jensen, Cedar Grove.

Frederick P. Nause, 2405 North Third Street, Sheboygan.

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Changes in Address

B. J. Meyer, Milwaukee, to Mayo Clinic, Rochester, Minnesota.

F. J. Hamernik, Chicago, to Vicksburg Clinic, Vicksburg, Mississippi.

W. E. Jones, Kelso, Washington, to 732 North Ninety-first Street, Seattle, Washington.

Elvira C. Seno, Wood, to Veterans Administration Hospital, Waukesha.

Laird McNeel, Burlington, to Fort Atkinson.

A. H. Twyman, Beloit, to 1211 Beacon Street, East Chicago, Indiana.

Henry Santina, Waupaca, to 2417 West Sixty-third Street, Chicago, Illinois.

A. M. Whiting, Ashland, to 2400 Vincent Avenue North, Minneapolis, Minnesota.

L. T. Baehr, Janesville, to 3510 Lucia Crest, Madison.

F. J. Flanagan, Little Chute, to Black Creek.

P. W. Smith, Black Creek, to 6 State Street, Reno, Nevada.

MARRIAGE

Dr. Harold W. Shutter and Mrs. Elizabeth Dyke Cooley, Milwaukee, on October 12.

BIRTHS

A daughter to Drs. Grant and Mildred Stone of Berlin on September 16.

A son to Dr. and Mrs. W. C. Strutz of Princeton on September 26.

DEATHS

A physician at Sparta for more than fifty years, **Dr. Hugh H. Williams,** 79, died at a hospital in Minneapolis on October 7. The doctor, who retired from active practice two years ago, was one of eighteen physicians admitted to membership in the Fifty Year Club of the State Medical Society at its 1948 Annual Meeting.

A native of Wales, the doctor was born on August 20, 1869. As a small boy he came to the United States with his uncle, who established residence in Monroe County. Doctor Williams attended Rush Medical College, graduating in 1896. He established his practice in Sparta shortly afterward, and, except for a period of service in the Spanish–American War, continued there until his retirement two years ago. Shortly after World War I he helped to establish the Sparta Clinic.

The doctor was a member of the Monroe County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and a son, Dr. Hugh H. Williams, Jr., of Sparta.

Dr. Elmer H. Gramling, 52, Milwaukee gynecologist and obstetrician, died at his home in Wauwatosa on October 8, following a long illness. He had retired in 1942, after twenty-two years of practice in Milwaukee.

The doctor was born at Dousman on March 9, 1896. He attended Marquette University School of Medicine, graduating in 1919. Serving his internship at the Milwaukee County General Hospital, he later took postgraduate studies at the Lying-In Hospital, New York, and at Cook County Hospital, Chicago. He served as an instructor in gynecology and obstetrics at Marquette University School of Medicine and was on the staffs of St. Luke's, Misericordia, and the Milwaukee County General hospitals.

He held membership in the Wisconsin Society of Gynecology and Obstetrics and the Wisconsin Academy of Surgery. Past treasurer of the Medical Society of Milwaukee County, he also was a member of the State Medical Society and the American Medical Association.

Survivors include his wife, four daughters, and a son.

Dr. C. D. Boyd, prominent Kaukauna physician and founder of the Riverview Sanitorium in Outagamie County, died at his home in Kaukauna on October 1. The doctor, who was 79 years old, had served as superintendent and medical director of Riverview Sanitorium for thirty-two years. He resigned from that position three years ago.

Born at Wisconsin Dells on June 6, 1869, the doctor studied at Northwestern University for two years before entering Rush Medical College. He received his degree in medicine in 1891 and later he took postgraduate studies in New York. Following brief practices at Auburndale and West Superior, he located in Kaukauna.

Doctor Boyd served for many years as city health officer of Kaukauna and had also been mayor at one time. In addition to serving as medical director of Riverview Sanitorium, he had been secretary of the board of directors since 1914. He held membership on the senior council of the Wisconsin Anti-Tuberculosis Association and in the Wisconsin Trudeau Society.

A charter member of the Outagamie County Medical Society and its second president, Doctor Boyd last year became a member of the Fifty Year Club of the State Medical Society. He was also a member of the American Medical Association.

Among his survivors are his wife, two daughters, and a son, Dr. George Boyd of Kaukauna.

Dr. Francis M. Bair, physician at Cuba City for twenty-eight years, died at his home in that community on September 25. He was 74 years old.

Doctor Bair was born in Upper Sandusky, Ohio, on September 20, 1874. He received his degree in medicine from the Baltimore University School of Medicine, Baltimore, Maryland, in 1899. Prior to locating in Cuba City, he practiced at Benton and Lake Mills.

The doctor was a member of the Grant County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his wife, a daughter, and a son.

Public Health Conference

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Wisconsin Association for Public Health
University of Wisconsin
Wisconsin State Board of Health

MONDAY AND TUESDAY
DECEMBER 20 AND 21

Wisconsin Memorial Union Theater
Madison, Wisconsin

The Program

Monday, December 20

9:00–10:00 Registration

10:00–10:30 Introductions by Carl N. Neupert, M. D., State Health Officer

Welcome
Oscar Rennebohm, Governor of Wisconsin
E. B. Fred, President, University of Wisconsin
L. G. Howell, City Manager, Madison

Presiding:
E. H. Jorris, M. D., Assistant State Health Officer

10:30–11:15 Health Units for the Nation—Haven Emerson, M. D., Chairman, Subcommittee on Local Health Units, American Public Health Association

11:15–12:00 Organization and Functions of a County Public Health Council—John W. Ferree, M. D., Associate Director, National Health Council

12:00– 1:30 Lunch—Tripp Commons Dining Room, Wisconsin Memorial Union

Presiding:
Charles K. Kincaid, M. D., Madison City Health Commissioner

1:30– 2:15 Community Health Surveys—Roscoe P. Kandle, M. D., Field Director, American Public Health Association

2:15– 3:00 Functions of a Local Health Department—Vlado A. Getting, M. D., Massachusetts Commissioner of Health

3:00– 4:30 Panel on Local Health Units:

Moderator: Carl N. Neupert, M. D.
Haven Emerson, M. D.
John W. Ferree, M. D.
Roscoe P. Kandle, M. D.
Vlado A. Getting, M. D.
Charles K. Kincaid, M. D.
Allan Filek, M. D.

6:00– 7:30 Dinner (no program)—Tripp Commons Dining Room, Wisconsin Memorial Union

8:00 Business Session for Formal Organization of the Wisconsin Association for Public Health —Wisconsin Memorial Union Theater

— See Reverse Side For Tuesday Program —

The Program

Tuesday, December 21

Presiding:
Allan Filek, M. D., Director of Local Health Administration

9:00– 9:45 Coordination of Hospitals and Health Departments—Basil MacLean, M. D., Director, Strong Memorial Hospital, Rochester, New York

9:45–10:30 The Functions of a Public Health Laboratory—G. D. Cummings, M. D., Director, Bureau of Laboratories, Michigan Department of Health

10:30–11:15 The Functions of a Sanitarian in a Local Health Department—Ellis S. Tisdale, C. E., Sr. Sanitary Engineer, United States Public Health Service

11:15–12:00 Fluorine in the Prevention of Dental Decay—Frederick S. McKay, D. D. S., Colorado Springs, Colorado

12:00– 1:30 Lunch—Tripp Commons Dining Room, Wisconsin Memorial Union

Presiding:
R. W. Bardwell, Ph. D., President, Wisconsin Public Health Council

1:30– 2:15 Local Public Health Mental Hygiene Activities—P. H. Stevenson, M. D., Sr. Surgeon, Mental Hygiene Division, U. S. Public Health Service

2:15– 3:00 The Public Health Nurse Rations Her Time—Margaret Taylor, R. N., Director, Public Health Nursing Course, University of Minnesota

3:00– 4:30 Panel on Local Public Health Programs:
Moderator: W. D. Stovall, M. D., Director, State Laboratory of Hygiene

Basil MacLean, M. D.
G. D. Cummings, M. D.
Ellis S. Tisdale, C. E.
Frederick S. McKay, D. D. S.
P. H. Stevenson, M. D.
Margaret Taylor, R. N.

7:30 Dinner—Dance—Informal—Tripp Commons, Wisconsin Memorial Union

Your presence here indicates that you are interested in improving the public health in your community. Do you know whether your water, milk and food supplies are adequately protected? Is there provision for searching out the spreaders of tuberculosis? What is being done to prevent the increase in the number of deaths due to heart disease and cancer? These are only a few of the searching questions which can be asked. Unless you have a full time county health department many of the basic public health activities that would improve the health of your community are only meagerly available. Think it over.

CARL N. NEUPERT, M. D.,
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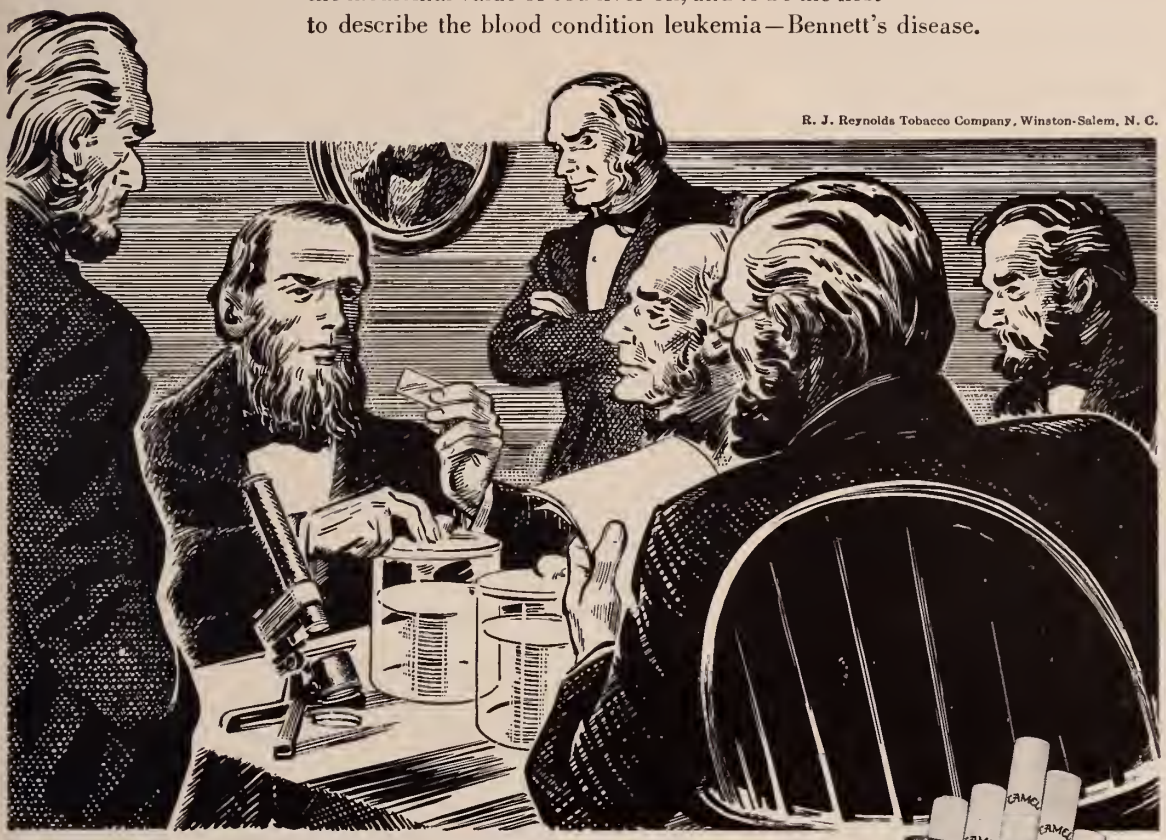

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Dr. Hilmar G. Martin, Milwaukee eye, ear, nose, and throat specialist, died at his home in Milwaukee on October 5. He was 55 years old.

A native of Milwaukee, the doctor was born on January 17, 1893. He attended the University of Wisconsin and Johns Hopkins University School of Medicine, receiving his medical degree from the latter in 1919. Following interneship, he established his practice in Milwaukee. He was certified by the American Board of Ophthalmology in 1938.

A past-president of the Milwaukee Ophthalmic Institute, he was a member of the Milwaukee Oto-Ophthalmic Society and a fellow of the American Academy of Ophthalmology and Otolaryngology. He also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. For many years he was chairman of the Committee on Scientific Research of the Medical Society of Milwaukee County.

He is survived by a sister.

Dr. Carl Vogel, a physician at Elroy for forty-four years, died at a hospital in Richland Center on September 26. The doctor, who retired from medical practice in 1945, was 74 years old.

Doctor Vogel graduated from the Bennett College of Eclectic Medicine and Surgery in 1901 and from Northwestern University Medical School in 1903. The following year he located in Elroy. In 1908 his brother, Dr. Clarence Vogel, joined him in practice, and this partnership continued until Doctor Carl retired in 1945.

During World War I he served as a major in the Army Medical Corps.

Doctor Vogel is survived by two sisters and two brothers, Dr. Clarence Vogel of Elroy and Dr. Ronald Vogel of Madison.

Dr. Louis F. Ruschhaupt, 69, associate professor emeritus of clinical medicine at Marquette University School of Medicine, died at a hospital in Milwaukee on September 30.

Born on March 10, 1879, the doctor received his degree in medicine from Rush Medical College in 1902, having completed premedical work at the University of Wisconsin, from which he was graduated in 1899. He interned at the Johnston Emergency Hospital in Milwaukee, and later took postgraduate study in Berlin and Vienna. During World War I, he was a captain in the Army Medical Corps. In 1937 he was certified by the American Board of Internal Medicine. Doctor Ruschhaupt served on the staffs of Milwaukee County, Deaconess, and Johnston Emergency hospitals in Milwaukee.

A fellow of the American College of Chest Physicians and a member of the Society for the Advancement of Science, he also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by a sister.

NINTH ANNUAL DEARHOLT DAY TO BE HELD NOVEMBER 22 AND 23

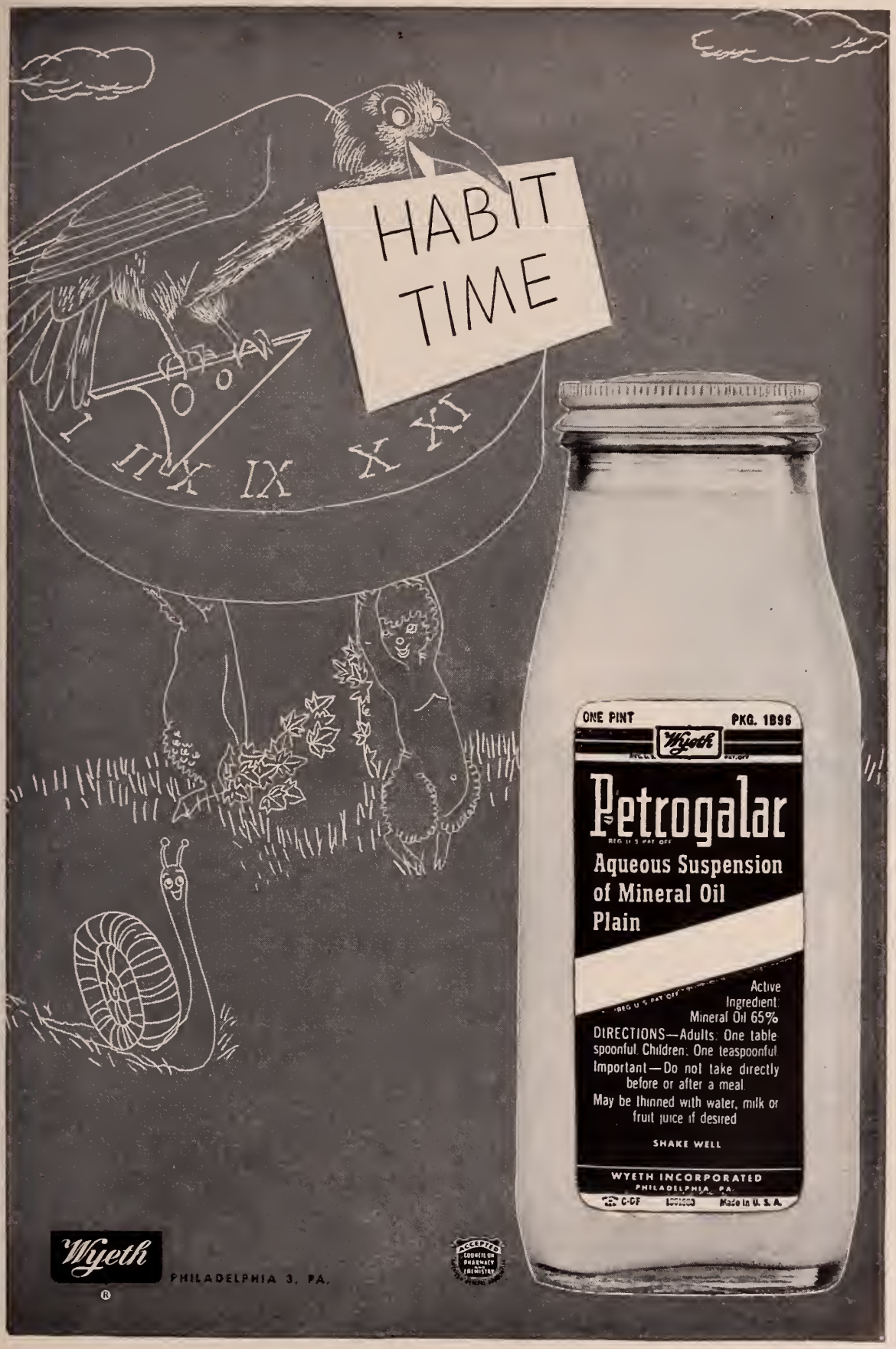
In cooperation with the Wisconsin Anti-Tuberculosis Association, medical organizations in Milwaukee and Madison will sponsor the Ninth Annual Dearholt Day in Milwaukee on November 22 and in Madison on November 23.

The program speakers will be Dr. Edith M. Lincoln, assistant professor of pediatrics at the New York University College of Medicine, and Dr. Florence B. Seibert, associate professor of biochemistry at the University of Pennsylvania.

At the afternoon program in Milwaukee, which will be held at the auditorium of the Marquette University School of Medicine, Dr. John S. Hirschboeck, dean, will preside. Doctor Lincoln will discuss "Tuberculosis in Children," and Doctor Seibert will present a paper on "Component Parts of the Tubercle Bacilli and Their Relation to the Tuberculin Test." Following a dinner at the University Club at 6:15, another scientific session will be held, at which Dr. Nina P. Mueller, president of the Milwaukee Women's Medical Society, will preside. At this meeting Doctor Lincoln will speak on "Chemotherapy in the Treatment of Tuberculosis in Children," and Doctor Seibert will discuss "Serum Changes of Diagnostic and Prognostic Significance in Tuberculosis."

In Madison the afternoon meeting will begin at 3 p. m. at the auditorium of the Service Memorial Institutes Building, Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, presiding. Doctors Lincoln and Seibert will repeat the subjects presented in Milwaukee. At 8:15 p. m. a scientific meeting will be held at the Madison Club, where members and guests of the Dane County Medical Society and the Wisconsin Trudeau Society will also be present. Dr. G. G. Stebbins, president of the Dane County Medical Society, will preside. Again the guest speakers will speak on the subjects presented in Milwaukee.

The Dearholt Day program began with funds left by the late Dr. Hoyt E. Dearholt, executive secretary of the Wisconsin Anti-Tuberculosis Association from 1908 to 1939. Friends of Doctor Dearholt have made it possible to continue its presentation.



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Inaugural Address of the 1948-1949 President

By MRS. MERLE Q. HOWARD
Wauwatosa

Mrs. M. Q. Howard
1948–1949 President

THERE is no need for me to tell you how much I appreciate the honor and also the responsibility you have given me, that of being your president in this our twentieth year. I have high hopes that this will be a year of great accomplishments for our organization. I assure you that I will fulfill my part to the very best of my ability to make this a successful year for the Auxiliary. I know that I can depend on every one of you as members of the Auxiliary to do her part toward this end. Mrs. Eustace A. Allen, then our national president, said at the convention held in Chicago last June that the success of the national auxiliary depended on the work done by the state auxiliaries. For their success they in turn depend on the work of the county auxiliaries, and the county auxiliaries on each and every member of their organization. So it is up to the members of our organization to do their share if we are to accomplish the work we set out to do at the beginning of our new year.

Once again we have been asked by our parent organization to stress increased membership, public relations and *Hygeia*. I would also like to see the program for better care of the mentally ill continued. These will be our chief objectives this year.

We can increase our membership by means of new members in already organized auxiliaries; the organization of new county auxiliaries; and, where this is not possible at this time, members-at-large in unorganized counties who will form a nucleus for an auxiliary at some date in the near future. The goal—every doctor's wife an Auxiliary member. As there are more than half of our counties that are not organized, you can see that we have a great deal of work to do in this field before we reach our goal. There was a great deal of work done this past year by your organization chairman. Since there could be no work done during the war or the years immediately following, it takes time to get this work started again. I am sure that our organization chairman will appreciate all of the help you can possibly give her in this field. We are a big state, and you may have very valuable contacts that would be of help to her.

You have all heard so much about public relations the last few years that I feel there is no need for me to say very much on this subject. We are asked by the American Medical Association to promote better feeling and understanding between the public and the medical profession at any and all times. We must, as it were, be ambassadors of good will. This may be done by providing a health day or days when possible; the health day programs would consist of lecture forums with question periods for the public. In connection with the lectures, exhibits pertaining to health problems pertinent to the public may be presented. If we as doctors' wives are to do our part in this work we must be well informed on medical legislation, prepaid medical care plans, and public health problems in general.

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One means of obtaining this information and becoming well informed Auxiliary members is by means of study groups and lecture forums in your own county auxiliaries. I cannot urge too strongly your support of such groups. I know this means work and hard work for our members. I know too how hard you are working already. It seems impossible for most of us to do one thing more than we are already doing, but I feel that in this field we must put forth that little extra effort this year to study and attend study groups and lectures on these topics. I take it for granted that you are all reading the Bulletin and *Hygeia*.

We have been urged to increase the subscriptions to *Hygeia*. You all know how important this is, as it is one more means of health education for the lay public, thus aiding in the public relations program. We have the honor of having Mrs. A. W. Hammond as national *Hygeia* Chairman this year. It will be a lot of work for her. I am sure that you will all outdo yourselves to help her. We do want her to be proud of her state.

Under Mrs. Hammond we made a fine start on our program for promoting interest in the care of the mentally ill and trying to help in every way to provide better care for them. We know how desperately the hospitals for the mentally ill need more trained personnel to take care of the ever increasing number of patients.

Legislation will be important this year and should be followed closely by all members. Your legislation chairman will be only too glad to help you in this matter.

When we are asked to stress certain projects, such as organization, public relations, *Hygeia*, this does not mean that the work of our other committees is to be slighted; far from it. Every one is important in the over-all picture. In a smooth running organization every committee is important, and all are quite dependent, one on the other, each one working for the good of all.

Once again I ask you for your support. The real success of our year does not depend only on your president, your officers, or your committee chairman, but on each and every member of all of the county auxiliaries. All working together I am sure that we will reach our goal.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Medical Clinics of North America. New York Number. Symposium on Psychiatry and Neurology. Pp. 853. Philadelphia and London, W. B. Saunders Company, 1948.

This number of *The Medical Clinics of North America* comes from the neuropsychiatric centers of New York and reviews a number of isolated phases of current thought in this field. Many of the articles will be of purely theoretic interest to the internist or general practitioner, but certain of them are well worth his careful reading and re-reading. Among these is "Headache: An Outline for Diagnosis and Treatment," by Kunkle and Wolff, in which the currently accepted mechanisms for the production of head pain are reviewed and classified. Familiarity with this outline should be of considerable help when faced with diagnostic problems of this type. Another very worthwhile article is by Rennie on the recognition and management of anxiety states. Dattner presents an excellent review and impartial summary of recent reports on the penicillin treatment of neurosyphilis, and Brickner an excellent, if somewhat discouraging, review of the present status of diagnosis and treatment in multiple sclerosis.—J. L. S.

Private Enterprise or Government in Medicine. Edited by Louis Hopewell Bauer, A. B., M. D. F. A. C. P.; Diplomate, American Board of Internal Medicine; Member, Board of Trustees, American Medical Association; President, Medical Society of the State of New York, 1947–48. Springfield, Illinois, Charles C. Thomas, Publisher, 1948.

In eleven chapters and one hundred seventy-five pages, the author presents the much disputed question of voluntary versus compulsory sickness insurance and the significance of this issue to the American people. His opinions favor the voluntary system, but his arguments are not based on bias or prejudice. They are substantiated by citations of experience in other countries and by refutation of many of the assumptions of the proponents of the compulsory system concerning the nature and extent of the problem of medical care and its relation to the health of the people.

He does not support those who declare that no change in medical care is needed. Instead he recognizes three groups, each one of which has its protagonists on the question of the distribution of medical care. They are the extremely conservatives, who are contending for the status quo ante; the extremely radical, who are determined to further a

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An intensive course in cardiology will be presented by the University of Wisconsin Medical School from December 13 through 17. The course will include current practical aspects of heart disease, rheumatic heart disease, current treatment of the failing heart, indications and uses of the various preparations of digitalis, the surgical aspects of congenital cardiac defects, electrocardiographic translations, and disorders of rhythm.

Drs. C. M. Kurtz and H. H. Shapiro of the Department of Cardiology of the medical school will direct the course, which will be focused for the practitioner of general medicine. Application should be made immediately to Dr. Llewellyn R. Cole, Coordinator of Graduate Medical Education, 418 North Randall Avenue, Madison 6, Wisconsin.

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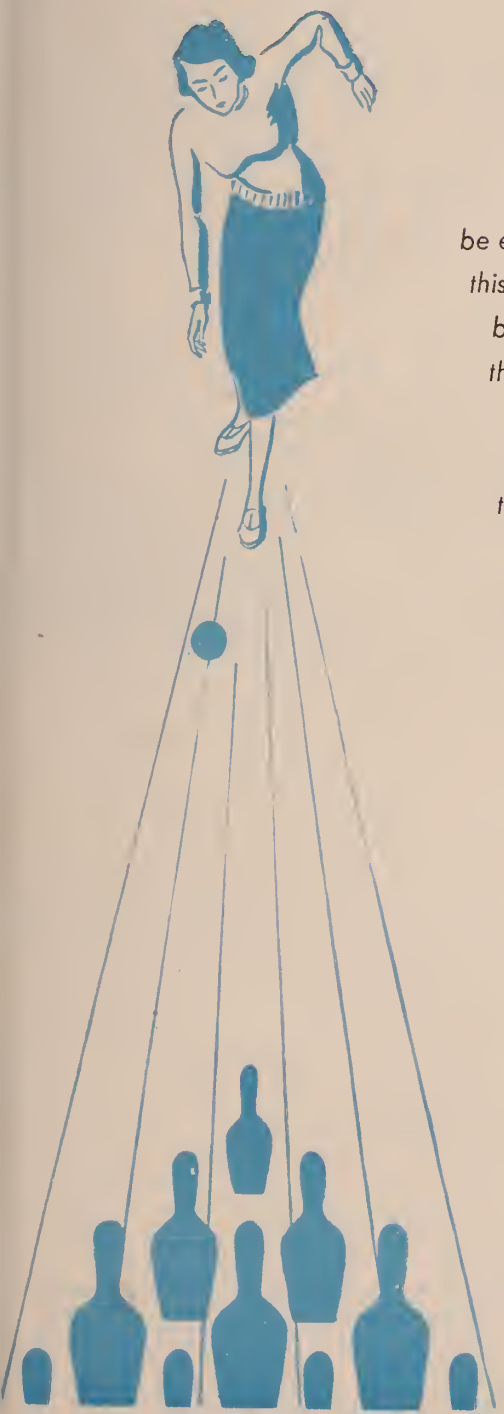

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paternalistic government; and the liberal group, who recognize the deficiencies in the present system of medical care and are interested in supplementing and replacing outmoded methods and practices.

The point of view of the author is ably supported from the beginning chapter, which is a brief historical review of the growth of the medical sciences and their influence on medical education, hospital development, and medical practice, to the last chapter which is entitled, "Ideals to be Met and Methods of Meeting Them."

He opposes the philosophy that security and health can be obtained for the individual by legislation or centralized administrative practices but declares himself in favor of government help when it is needed and when this help is administered locally by the people who are to be assisted. He maintains that medicinal care has been portrayed as synonomous with health by those who wish to use this avenue to parasitize the individual on his government and to indoctrinate him with the idea that life, liberty and the pursuit of happiness can be piped to him through governmental administrative channels.

The book is replete with statistical data on selective draft rejections during the last war; upon the accomplishments of disease prevention in our country; upon the development of state compulsory sickness insurance in foreign countries and its effect upon the health of the people in those countries.

The book is recommended as important reading for all citizens and especially for high school students because of its clear focus on the responsibilities of citizens in a country of free people.—W. D. S.

The Differential Diagnosis of Jaundice. By Leon Schiff, Ph. D., M. D., Associate Professor of Medicine, Department of Internal Medicine, University of Cincinnati Medical School; Director, Gastric Laboratory, Cincinnati General Hospital. Pp. 313. Chicago: The Year Book Publishers, Inc., 1946. Price: $5.50.

This book is an extensive review of the clinical features of many of the causes of jaundice, along with a running commentary as to differential points which are of value in establishing their presence. Perhaps regrettably, since any adequate differential diagnosis of jaundice must be predicated upon an understanding of the available knowledge of the physiology and chemistry involved, these subjects are treated only briefly. Also unfortunate, in the reviewer's opinion, is the limited attention given to the hemolytic forms of jaundice, since many of the cases referred for consultation after previous fruitless study prove to be of this order. Aside from these criticisms, however, the book can be highly recommended. Its presentation is clear, both sides of controversial questions with the pertinent evidence are clearly and yet simply presented, the illustrations are of good quality, and the printing format convenient for reference. A very valuable feature is the excellent bibliography provided in readily available footnote form. Another excellent feature is the synopsis of important laboratory methods, which should give to the reader unfamiliar with them an appreciation of the significance of the various tests used in the study of the jaundiced patient. It is felt that this volume will prove of value both to the general practitioner and to the specialist in the field.—J. L. S.

May's Manual of the Disease of the Eye. For Students and General Practitioners. Nineteenth edition. Revised and edited by Charles A. Perera, M. D., Assistant Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Assistant Attending Ophthalmologist, Presbyterian Hospital, New York. Pp. 521, with 387 illustrations, including 32 plates, with 93 colored figures. Baltimore: Williams & Wilkins Company, 1947. Price $4.00.

The nineteenth edition of "May's Manual of the Diseases of the Eye" follows closely the general outline of the more recent editions. It has been brought up to date by the inclusion of the well accepted advances in ophthalmology during the past three years. Most outstanding additions are penicillin therapy, modern theory of color vision and its anomalies, ocular brucellosis, and congenital cataract following maternal rubella.

The book, as previously, is beautifully illustrated; the colored plates are excellent.

May's Manual continues to deserve a place in the library of every practitioner of medicine and student of ophthalmology. The book adheres to the basic and factual aspects of its subject and is shorn of excess wordage.—P. A. D.

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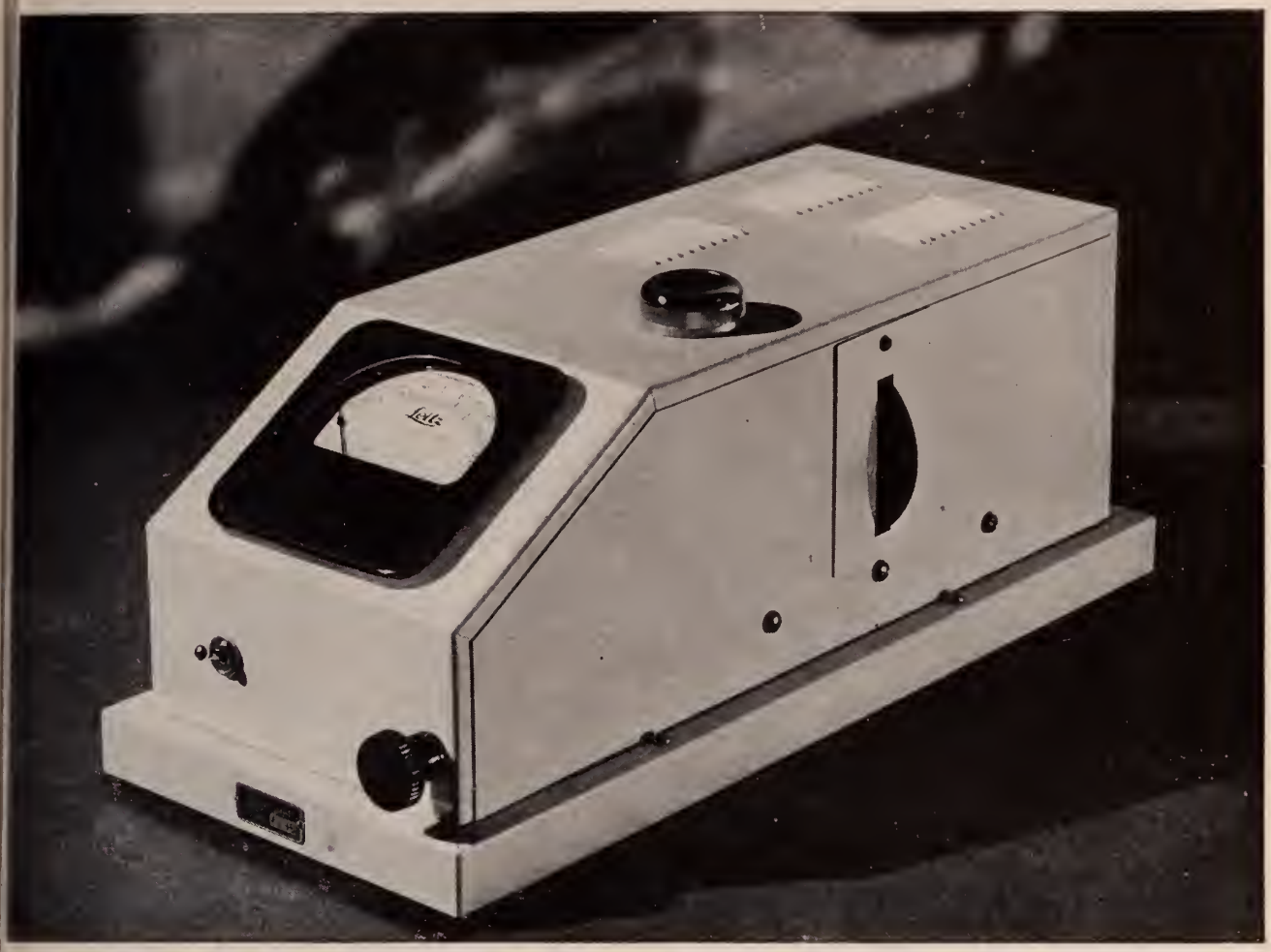

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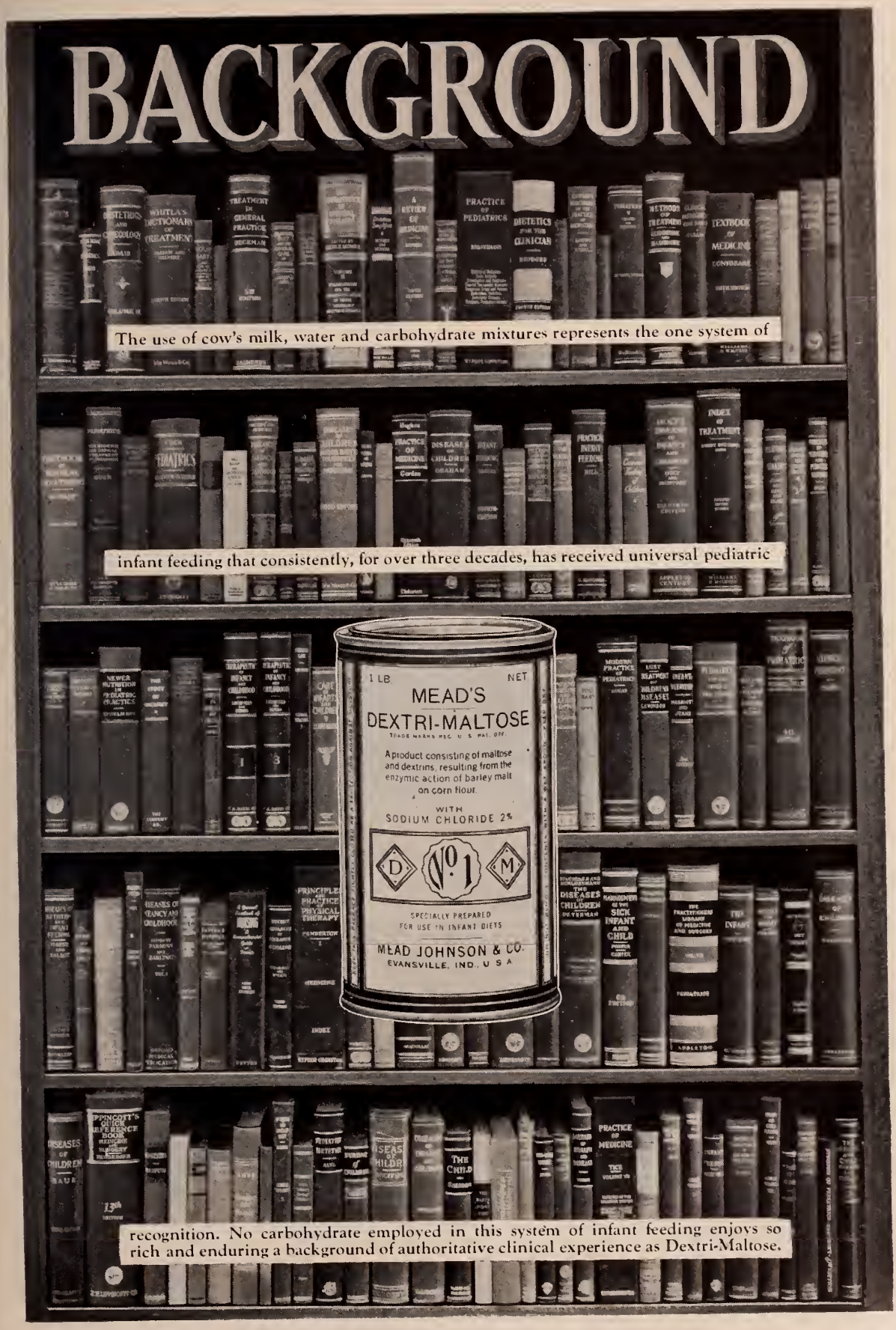
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COMMENTS ON TREATMENT

(Continued from page 1103)

should be removed before great distention develops, since distention seriously curtails the appetite.

On such a program a significant proportion of patients with alcoholic or nutritional cirrhosis may be expected to show improvement, remission of symptoms, or prolongation of life beyond the usual expectancy. Experience indicates that in cases of nodular or postnecrotic cirrhosis and in others of obscure etiology results will be poor.—J. L. SIMS, M. D.

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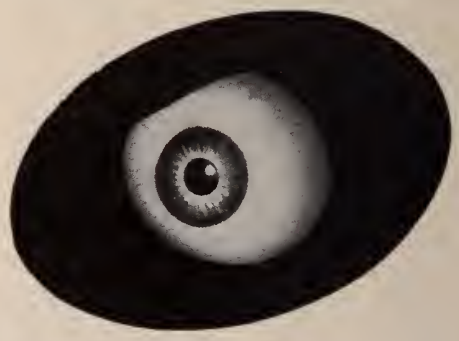

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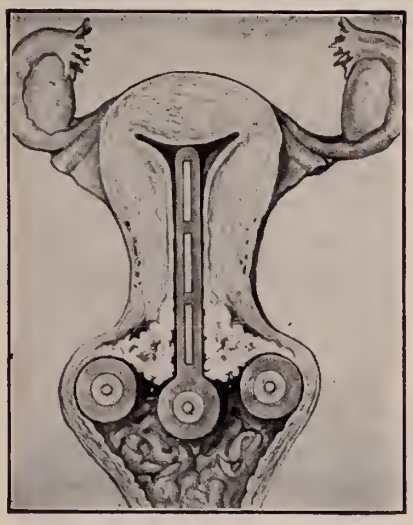

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I was very much impressed by the smoothness with which everything rolled.

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Sheppard and Enoch Pratt Hospital
Towson, Maryland

I enjoyed participating in the meeting, and . . . I admired the efficiency and enthusiasm of the society.

JOSEPH L. BAER, M. D.
Chicago, Illinois

I want to tell you how much I enjoyed my visit in Milwaukee while in attendance at your State Meeting.

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Let me express my grateful appreciation for the kind hospitality extended to me during my visit with you and the Society in Milwaukee. I should like to say that it was one of the most stimulating meetings I have ever attended and that this added much to my enjoyment.

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Professor of Surgery
Baylor University College of Medicine
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NORMAN H. TOPPING, M. D., *Associate Director*
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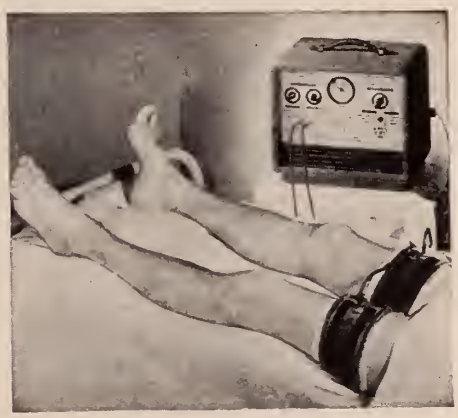

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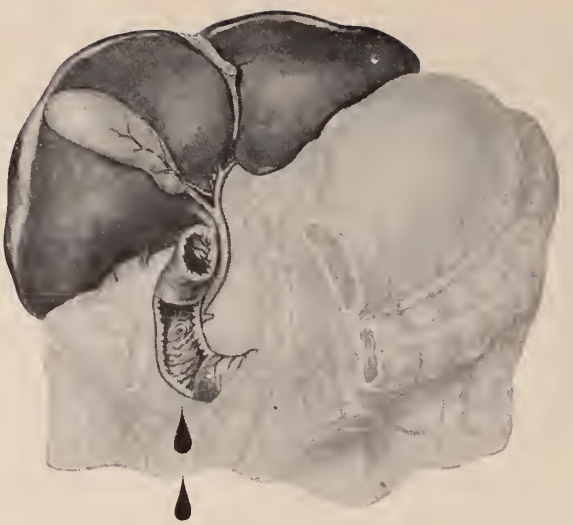

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	1075
Ahlstrom Surgical Company	1064
American Meat Institute	1070
Ames Company, Inc.	1140
Audiphone Utilities	1139
Ayerst, McKenna & Harrison, Ltd.	1127
Barr X-Ray Company	1130
Bellevue Place	1132
Benson Optical Company	1132
Bergmann Prescription Center	1115
Bilhuber–Knoll Corporation	1113
Camel Cigarettes	1119
Camp, S. H. and Company	1143
Central Drug	1124
Ciba	1067
Coleman and Bell	1137
Continental Casualty Company	954
Cook County Graduate School of Medicine	1137
Doerflingers	1137
Eaton	1078
Endocrine Laboratories	1135
First Central Dispensary	1115
Hotel Schroeder	1137
House of Bidwell	1130
Hurley X-Ray Company	1139
Ivanhoe Treatment, Inc.	1135
Jensen Brothers Prescriptions	1124
Kennedy–Mansfield	1138
Lilly, Eli and Company	facing page 1079
Lov-é Brassieres	1076
Luzier's Cosmetics, Inc.	1123
M & R Dietetic Laboratories	1117
Mallatt Pharmacy	1115
Massachusetts Protective Association	1130
Mather Pharmacy	1124
Mayer Drug	1124
Mead Johnson and Company	1131, 1142
Medical Protective Company	1068
Milwaukee Optical Company	1130
Milwaukee Sanitarium	1144
Nestlé's Milk Products, Inc.	1077
New World Life Insurance Company	1134
New York Polyclinic	1128
Orthopedic Appliance Company	1139
Page Milk Company	1074
Parke Davis and Company	1062, 1063
Philip Morris	1066
Physicians and Hospitals Supply Co.	1129
Physicians Casualty Association	1137
Physicians Radium Association	1139
Pogue, Mary E. School	1139
Prescription Pharmacy	1115
Professional Business Service	*Forum* 5
Radium Emanation Corporation	1133
Radium Service Corporation	1135
Rennebohms	1115
Rentschlers	1138
Rexair	1073
Riggs Optical Company	1065
Rogers Memorial Sanitarium	1144
Sacred Heart Sanitarium	1115
St. Croixdale Sanitarium	1065
Schering	1071
Schlintz Bros. Drug Store	1124
Searle, G. D. and Company	1111
Shorewood Hospital Sanitarium	1113
Squibb	1069
Summit Hospital Sanitarium	1133
Time Insurance Company	*Forum* 3
Upjohn	1125
Winthrop–Stearns, Inc.	1072
Wyeth	1121

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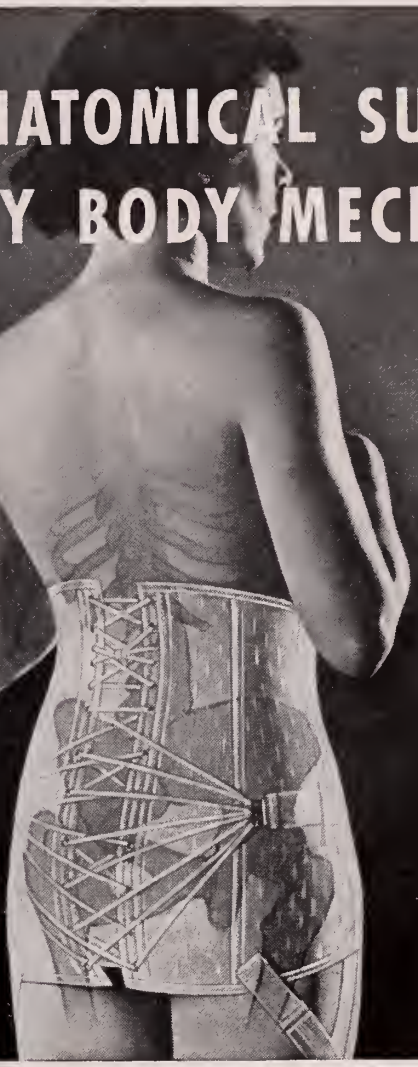

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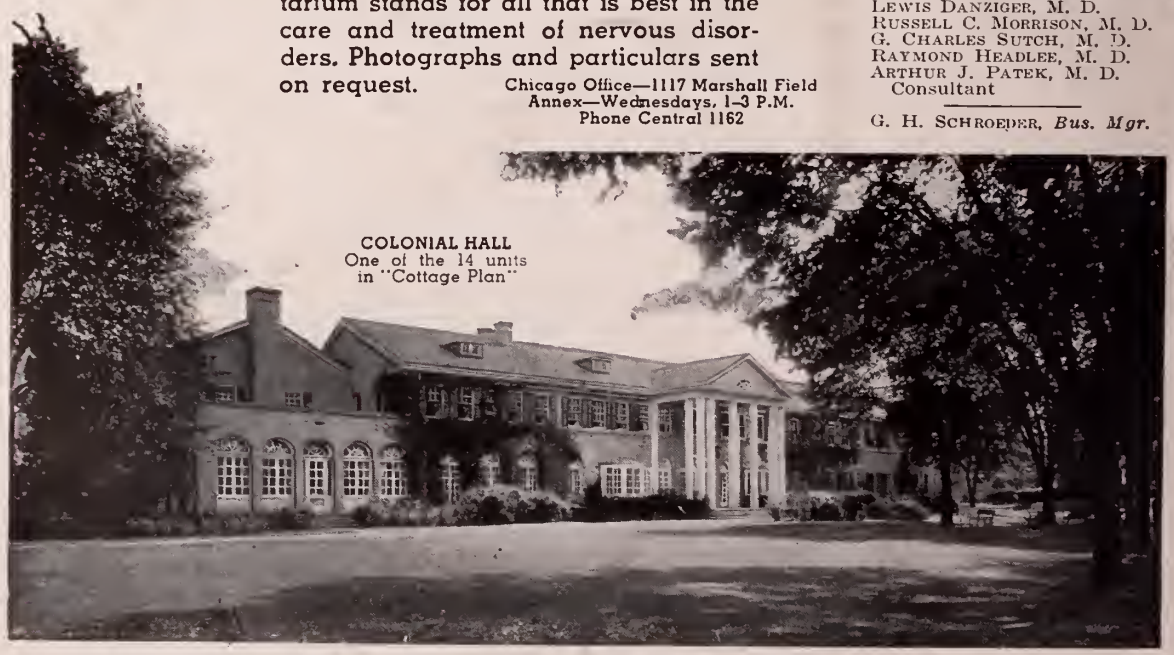

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
President's Annual Dinner Address, by W. D. Stovall, M. D., Madison	1163
Bladder Tumors; Their Diagnosis, Treatment, and Prognosis, by James C. Sargent, M. D., Milwaukee	1166
Strangulated Inguinal Hernia in A Man of 88 Years; Operation and Recovery, by V. S. Falk, Jr., M. D., Edgerton	1172
Placenta Accreta, by Benjamin E. Urdan, M. D., and Alvin M. Kurzon, M. D., Milwaukee	1174
The Management of the Surgical Diabetic Patient, by Robert S. Baldwin, M. D., F. A. C. P., Marshfield	1177
Acute Intestinal Obstruction in the Patient over 60 Years; Review of Cases, by Harold B. Haley, M. D., Fort F. E. Warren, Wyoming, and Arnold S. Jackson, M. D., Madison	1180
Bronchopulmonary Segments and Variations in Pulmonary Vascular Patterns, by Arthur B. Appleton, M. D., London, England	1185
Notes on Clinical Pathology	1186
As It Looks to Your State Board of Health	1187

EDITORIALS

The President's Page	1189
What Now? by L. Howard Schriver, M. D.	1191

MISCELLANY

	Page
Statement on Dues for 1949 by Reference Committee on Resolutions and Amendments to the Constitution and By-Laws	1188
As It Looks from the Wisconsin Public Health Council	1192
Income Tax Provisions Affecting the Medical Profession	1193
Transactions of the 1948 Regular Session, House of Delegates, State Medical Society of Wisconsin	1209
Attendance of House of Delegates, Milwaukee, October 3, 4, 5, 1948	1227
Statement by State Board of Medical Examiners on Licensing Foreign Physicians	1229
Society Proceedings	1230
News Items and Personals	1234
And About the Third and Twelfth Districts	1236
Society Records	1238
Deaths	1240
The Woman's Auxiliary	1242
The Journal Bookshelf	1248
Coming Events	1252
Physicians' Exchange	1254
Index to Advertisers	1256
Index to Volume 47, The Wisconsin Medical Journal	1257
List of Executive Officers of County Medical Societies	1265

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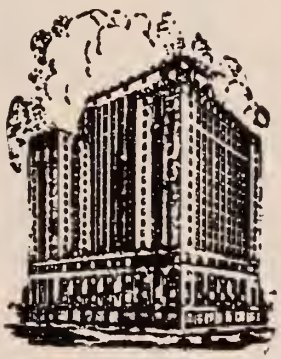

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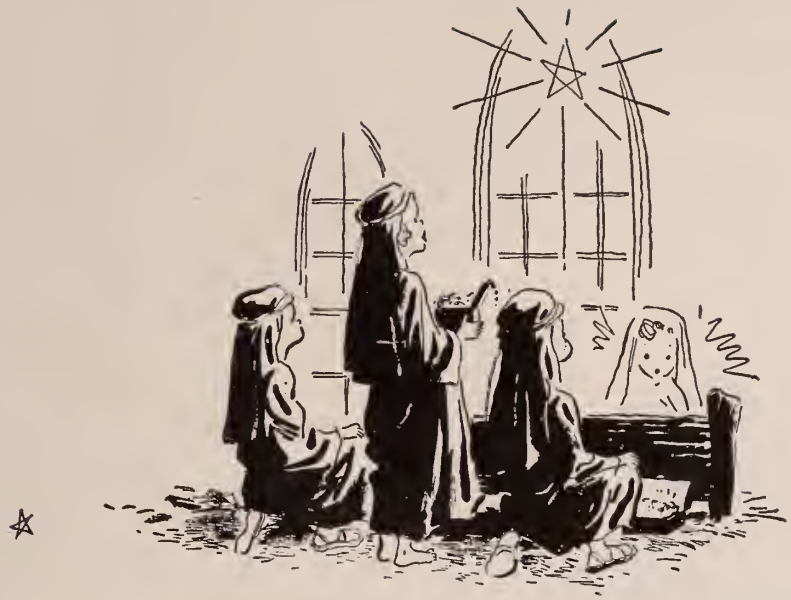

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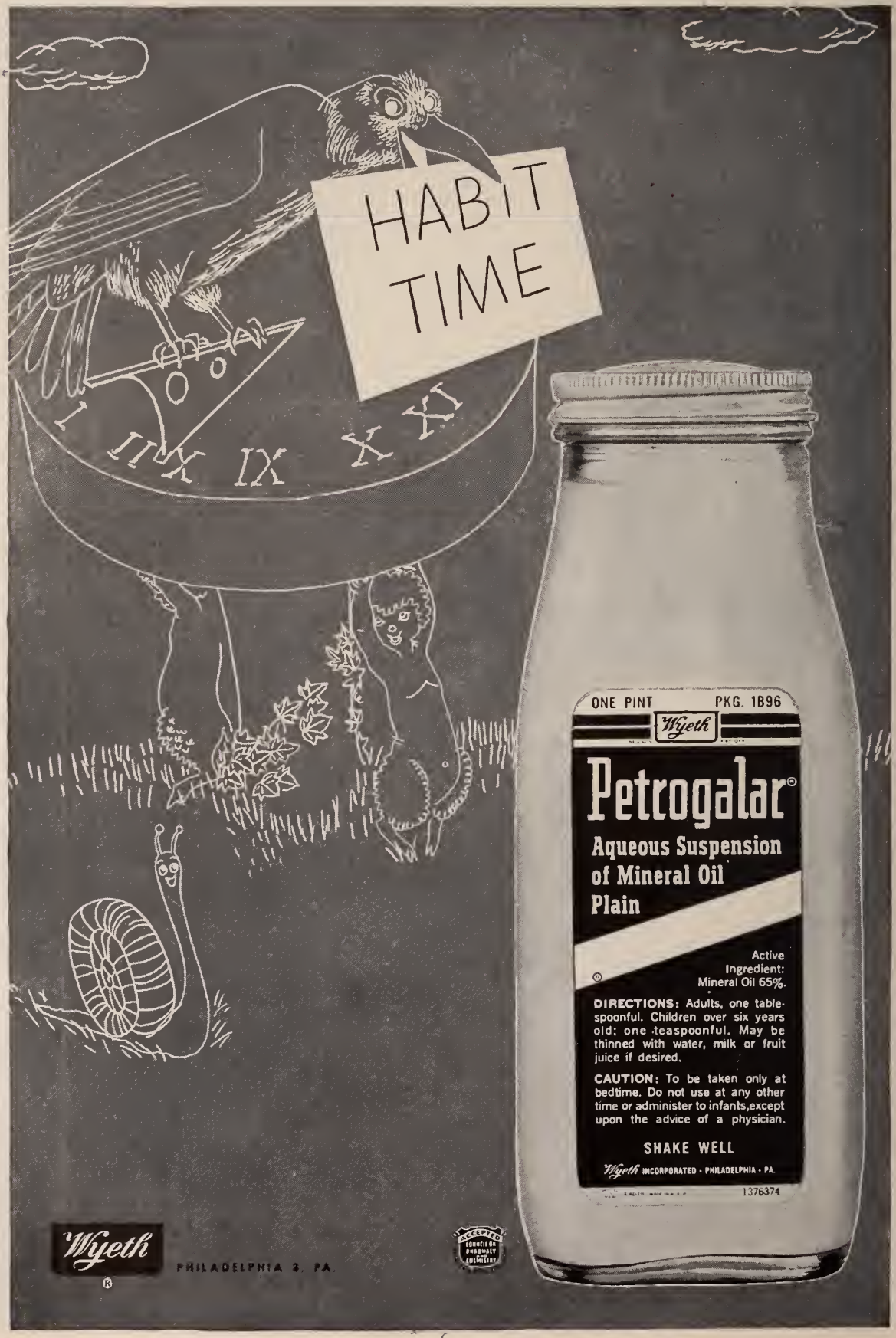
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*Philip Lewin, M. D., F.A.C.S.
Backache and Sciatic Neuritis,
Chapter XXXIX, Page 580
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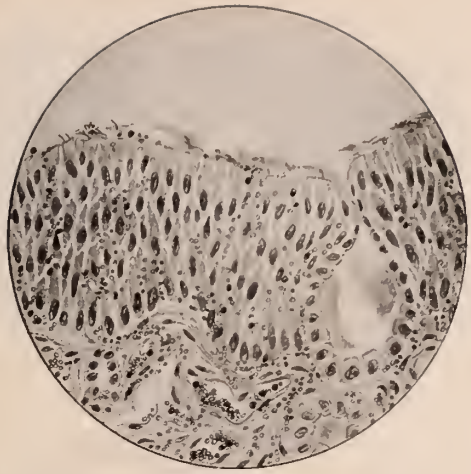

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THE WISCONSIN MEDICAL JOURNAL

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President's Annual Dinner Address

By W. D. STOVALL, M. D.
Madison

IN CHOOSING a subject about which to talk on this occasion, it seemed appropriate, in this year of Wisconsin's Statehood Centennial, to review briefly the last one hundred years of medical practice and the part it has played in the social order of the time. In order to get a perspective of this, it is necessary to include a glimpse of the period immediately preceding, that is, the period including the territorial days. It seems appropriate not only because this is the one hundredth anniversary of our state but because developments which have taken place during these one hundred years seem to have confused us as much as they have improved some of the aspects of human living and health.

Christian civilization is threatened by those who are worshipping at the shrine of physical science. Group organizations are more respected than the individual in the group, and government management more desired than individual freedom. The place of medicine in our social order is confused, not because of the advances of science but because of rationalizations from fragmentary knowledge. In this confusion medicine has been romanticized but the doctor stigmatized, so a brief review of the happenings that have taken place the past years may throw some light on our present predicament and be of some consolation to the doctor who feels that in our time he is beset with more "isms," "schisms," more quackery and fakery, and more false claims than during any previous time.

Dispute and controversy over methods of cure and prevention of disease are not peculiar to our time. Neither is the attack on the doctor and his methods of practice. Because he is the councilor in distress and despair he has always been a part of the life of his community, and he has had to take the bitter with the sweet. The greater the prevalence of illness and the more meager the state of knowledge, the more he is beset by those making false claims and professing unsound philosophies.

During the eighteenth and nineteenth centuries, people were moving westward in masses, there to encounter danger; dangers of the wilderness and deprivations and hardships which that entailed. The Indians were not the worst of the dangers. There was disease. The country west of the Alleghenies was reputed to be a sickly area. Death was a frequent visitor to the home of every pioneer. The death rate, not the birth rate, determined the character of the population.

All kinds of communicable diseases were prevalent —small pox, scarlet fever, lockjaw, typhoid fever, pneumonia, and, in 1832, even plague.

In a period when knowledge of disease was meager, when epidemics were of frightening proportion, endemic disease prevalent, when the death rate was high and old age was rarely attained, physicians were harrowed by cultists and quacks of many kinds and varieties.

This era of confusion was drawing to a close. Medical science was advancing; although bacteria had not been recognized as the cause of disease, ether anesthesia had been discovered. Erastus B. Wolcott of Milwaukee in 1862 was reported to have done a nephrectomy eight years before the first one reported from Germany. To Dr. Solon Marks of Milwaukee goes the credit for an even more daring operation. In 1870 he removed a bullet from the region of the heart of a Civil War veteran.

The regular doctors organized the Medical Society of the Territory of Wisconsin in 1841, and the name of the Society was changed to the Medical Society of the State of Wisconsin in 1848, when Wisconsin became a state. The physicians in this era were interested in public health. A committee, which included Nicholas Senn, was appointed to solicit the legislature for the passage of a law creating a State Board of Health. This committee made a report which announced the creation of Wisconsin's State Board of Health by the legislature of 1876.

Since its organization, the State Board of Health has been composed largely or entirely of physicians. The first health officer was Dr. J. T. Reeve of Appleton, who was appointed in 1876, served eighteen years and was president of the State Medical Society in 1875. Dr. C. A. Harper was the leader over a forty year period and was president of the State Medical Society in 1931. During these years Wisconsin progressed rapidly in the application of sanitary sciences and those methods of medical practice which have for their purpose the control and prevention of disease. The profession of the state has through

* Presented at the Annual Dinner of the State Medical Society, Hotel Schroeder, Milwaukee, October 1948.

this board made a record of which it can be proud, and it signifies the interest of the profession in the welfare of the people. The present state health officer, Dr. Carl Neupert, is an example of the type —medically educated and technically trained in professional public health administration—to whom we can confidently look for the kind of leadership to which we are accustomed. He has associated with him a group of specialists in various fields of public health practice and administration as his advisors and assistants. The State Society can take pride in the part which it has played in the development of public health practice in our state.

The nineteenth century was drawing to a close. Science was advancing rapidly. In Europe there was brought into focus by Louis Pasteur, Robert Koch, and a large group of other bacteriologists the results of two centuries of investigation into the cause of fermentation. Richard Boyle in 1642 said: "Understand the cause of fermentation and know the cause of disease." These bacteriologists indeed found the cause of fermentation, and they also found the cause of many of the epidemic diseases that had beset the lives of the pioneers who moved into Wisconsin and other central and midwestern states.

A new era was begun. An epic closed. The era begun by Sydenham and enlarged and reenforced by Morgagni and others was ending. The era of the application of the science of bacteriology to the control and prevention of disease was initiated. New types of medical practice were introduced. This new type of medicine and medical practice entered to take its place beside the old, the recognition of disease by syndrome and gross anatomic deformity and the treatment of late or terminal disease. With it also came new problems of social welfare. It was to be expected—as in the period of the nineteenth century when the botanics and other cults were practicing—that we should now get a flood of new "isms" based upon this new knowledge; since the physician has always been a part of the life of the community of this period, he has been caught in the maelstrom of social ideologies, but, as in the past, he has to take his part in the promotion of public welfare in whatever way it is shown that it can be done in a scientific manner.

In 1887 Mr. Chamberlin became president of the University of Wisconsin. The State Medical Society had been interested in the establishment of premedical courses in the new and rapidly advancing sciences which we now sometimes refer to as the "premedical sciences." Such courses were prompted through the initiative, in all probability, of Dr. John M. Dodson, and, though they were first called "special science courses antecedent to medicine," in 1892 the title was changed in the catalog of university courses to "Pre-Medical Courses." With these courses as a beginning, medical education in the university took on intellectual fiber and strength through such men as Dr. E. A. Birge, Dr. H. H. Russell, Dr. William Snow Miller, Dr. William D. Frost, and, at a somewhat later date, Dr. C. R. Bardeen. Dr. John B. Dodson later became dean of Rush Medical School and, still later, chairman of the American Medical Association's Council on Health and Public Instruction.

In 1905 the American Medical Association initiated a lay and professional educational campaign for the control of cancer through a committee which grew into the present council on Health and Public Education, now under the direction of Dr. W. W. Bauer, formerly epidemiologist for the City Health Department of Milwaukee and, just before joining the American Medical Association, the health officer of Racine. This beginning of a movement to control cancer was soon joined by the American Gynecologists' Society, the Clinical Surgeons of North America, and the North American Congress of Physicians and Surgeons. It was due to the united effort and initiative of these groups that the American Society for the Control of Cancer was organized in the Harvard Club in New York City on May 12, 1913. Our own medical society joined this movement against cancer in 1922. It was active in the organization of the Women's Field Army for the control of cancer in Wisconsin and is still active with the present campaign conducted under the auspices of the Wisconsin Division of the American Cancer Society. It was with money loaned by the State Medical Society to this unorganized group who were initiating the Women's Field Army of Wisconsin, that the first year's work was done. Without this help the present intensive educational and research program conducted throughout the nation and in our state for the control of cancer would have been delayed for many years.

It is no accident then, or mere chance, that the Legislative Council this year turned to the medical society to aid them in a better understanding of the needs of the Board of Health. This Council, whose business it is to examine into the needs and activity of all phases and departments of state government for the purpose of making recommendations to the Legislature concerning their needs and requirements, requested the State Medical Society to appoint a committee to look into the needs and present methods of operation of the State Board of Health.

The State Society accepted this responsibility and immediately brought together a committee of especially trained physicians whose career has been made in public health administration and teaching. To it was added representatives of the medical practitioners from the State Society, a man prominent in state government and one prominent in business administration. The public health members of the committee were chosen from outside the state and because they had national reputations in special fields of public health practice.

This committee worked for many months completely reviewing the previous report and the activities of the State Board of Health. They have made their report. The Legislative Council has expressed its appreciation for the great amount of work which

was devoted by these men to assist them in maintaining good democratic government. It is an example of free people working out their own problems in the field of public welfare. We are all proud that as doctors we could render this service of citizenship in a country where freedom is the highest function of government.

There are other problems which have come with the advance in science and the industrialization of the nation. Not the least of these is the demand and need for sickness insurance. With the mounting cost of living, the cost of illness has also risen. This is evident in the cost of hospitalization and all items which contribute to the care of the sick. Insurance is an accepted method in our country for spreading the cost of catastrophic disaster to whatever that may be due. Sickness comes in this category and some method for spreading this cost over the sick and *the well* to equalize it among all of us is a needed social reform. The difficulty, however, is in devising a method which will preserve the high type of individual medical care to which our citizens are accustomed and the freedom of the physician to supply it without being subject to interfering directives. It is doubly difficult to attain when, in addition to the complexities offered by conditions incident to the practice of medicine, there is added the stupendous hazard of opening a flank to the group who are using the need for sickness insurance to invade human rights and freedoms of all kinds by creating an authoritarian government and thus reducing free people to the state of serfdom, or at least parasitizing the individual on his government until he is no longer able or willing to provide for himself.

The press and the radio have told the profession that it is the business of the doctors to provide a system of sickness insurance or accept compulsory insurance. The doctors have hesitated because of their inexperience in operating in a field of such large economic proportions. But, cautiously they have proceeded, until now it appears that there are in operation systems which will offer an opportunity to spread the cost of illness over the group which is self-supporting. The group which is not self-supporting needs much more than sickness insurance. They need public assistance for most of the necessities of life. The physicians service plans now offered in our state and most of the other states are growing rapidly and expanding coverage each year that they are in operation. With good management and unanimous cooperation between the physicians and the public we will have organized another frontier of human welfare by the effort of free people working in the framework of a free government.

Great has been the contribution to medical practice by the advancement of science. Medical education has advanced with science; hospital development and medical practice have advanced with medical education. The artful practice of scientific medicine has taken the place of folk medicine. However, there are those who seem to think that advances have come too slowly because of the conservatism of the doctors, but in no other period of history is there revealed such great progress in so short a period. It is not denied that the doctor is cautious. By tradition, by training, and by practice he has learned that his technics and practices determine health or invalidism, life or death, for his patient. He cannot follow unsafe and unsound philosophies rationalized out of fragmentary knowledge. His responsibilities are great in a society where the individual and his life are respected and sacred. To him individuals are not expendable resources. He fears the too passionate reformer. He knows what Dr. Allen Greg has so aptly stated:

> "Since virtues have their defects, we may die of what too passionately we live for."

The physician's caution is the patient's safeguard against the defects of virtues.

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Bladder Tumors*

Their Diagnosis, Treatment, and Prognosis

By JAMES C. SARGENT, M. D.
Milwaukee

J. C. SARGENT

Doctor Sargent, clinical professor and director of the division of urology of Marquette University School of Medicine, received his medical degree from Ohio State University College of Medicine in 1915. President of the State Medical Society in 1938, he has also served as president of the Medical Society of Milwaukee County and of the North Central Section of the American Urological Association.

IT IS rare indeed that a person comes to learn that he has a tumor of the urinary bladder except through the advent of a spell of gross, total hematuria. Very rarely a pathologic fracture or some other form of metastatic pathology starts a search for a primary tumor that finally ends in the urinary bladder. Similarly, a very, very few bladder tumors are found in the course of a general urologic examination or through the routine of periodic cystoscopy of those who, working long and intimately with the analine dyes, are notoriously prone to have cancer of the bladder develop. By and large, however, it is the startling experience of an episode of gross hematuria—sudden to come, completely without other symptoms and soon to go—that tells the story.

When, after months or years of occasional episodes of hematuria, bladder cancer has progressed to the point of deep vesical and perivesical induration with extensive sloughing of the tumor mass, other symptoms develop which must be recounted if only as a matter of academic interest. Little of clinical usefulness can be attached to these late symptoms, however, since any diagnosis that awaits their confirmation can hardly be of practical value to the patient. If cancer of the bladder is to be prevented or cured, the presence of tumor must be recognized long before these distressing terminal symptoms have developed.

When bladder cancer has developed to the point of frank sloughing, heavy infection of the bladder cavity inevitably follows. Hematuria, either gross or microscopic, becomes constant and painful, and frequent urination become distressing, often distracting. If massive malignant infiltration surrounds and strangles either of the two ureteral orifices, renal pain and sepsis develop, announcing pyonephrotic destruction of the kidney. And if the internal urethral orifice be caught in the mass of malignant induration, difficulty of urination develops and bilateral pyonephrosis soon adds failing renal function to the clinical picture. Indeed, it is the urosepsis resulting from renal damage of this sort that ultimately leads to death in most cases of bladder cancer. In rare cases a cancer of the bladder dome will attach itself to and invade a loop of intestine, producing intestinal symptoms and leading finally to an enterovesical fistula. When one with long-standing hematuria begins voiding gas and fecal matter, one need hardly cystoscope a patient to know what has occurred. Similarly, when a woman becomes incontinent after months or years of hematuria, one hardly need examine her to know she has a cancerous vesicovaginal fistula. And, finally, the symptoms of generalized malignancy are too familiar to need relating.

Time was when it was quite proper to look upon a few days of simple hematuria something as a nosebleed. Some doctors still do, but their ranks are thinning and their days are numbered. Fortunately, through just such meetings as this the word is getting around—both in and out of the profession—that when anyone bleeds from any of the body orifices, both he and his physician had better find the reason why. Coughing blood, vomiting blood, urinating blood, bleeding from the bowel, and any unnatural bleeding from the vagina all mean business. And often enough to make careful investigation mandatory, such bleedings mean cancer.

There are two points in connection with hematuria that need emphasis as you look at figure 1. It has been drawn to portray the significance of total gross hematuria, not microscopic hematuria and not terminal urethral bleeding. Were a similar diagram drawn to portray the circumstances under which miscroscopic red cells are found in the urine, nephritis would occupy nearly the entire circle. And if we were to portray the significance of terminal bleeding—bleeding from the urethra after the bladder has emptied itself of its normally clear urine and is down to squirting out the last few drops—the entire circle would be occupied almost completely by simple congestion of the mucosa of the bladder neck. But when a person voids a urine grossly bloody from start to finish, it means that something somewhere above the bladder neck is bleeding actively. Then, as may be seen from the

* Presented as part of a Tumor Postgraduate Course at the University of Texas School of Medicine; Galveston, Texas; May 31 to June 3, 1948.

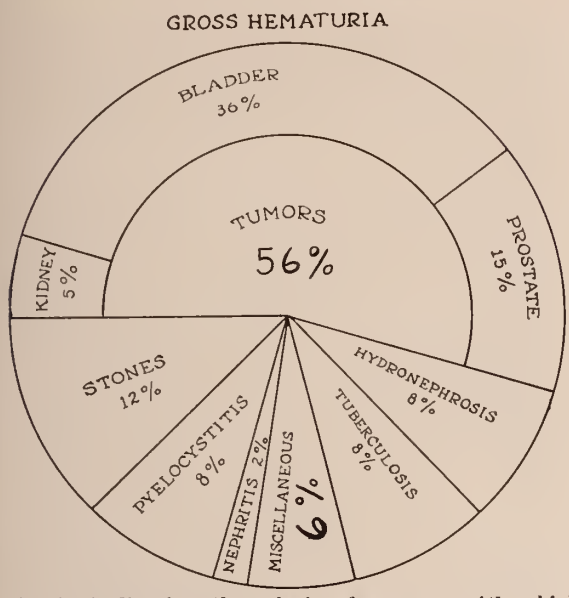

Fig. 1.—Indicating the relative frequency with which common urologic diseases are found as the cause of gross total hematuria.

diagram, the chances are better than even that the patient has a tumor, and the chances are better than one to two that he has a tumor of the bladder.

Once hematuria has occurred and its warning is heeded, the recognition of a bladder tumor is quite easy and direct. Cystoscopy simply must be done. And I would stress the importance of doing cystoscopy at once—while the patient still is bleeding. There is no particular advantage to immediate cystoscopy if the patient proves to have a bladder tumor, since a tumor sitting on the bladder wall and staring one in the face could hardly be missed by the cystoscopist, bleeding or no bleeding. But if there is no tumor within the bladder to explain the hematuria, it is of immeasurable assistance to the cystoscopist to have a flow of blood to guide him to the source of bleeding—a bleeding varicosity in the mucosa overlying an enlarging prostatic lobe or, more helpful still, an intermittent spurt of bloody urine from one or the other ureteral orifice to indicate which one of the two kidneys is doing the bleeding.

If treatment is to be at all definitive and prognosis anything more than pure speculation, there is much more to the diagnosis of a bladder tumor than its mere cystoscopic recognition. Its degree of malignancy must be determined. And the depth of invasion into or through the bladder wall must be determined. It is perfectly obvious from the three sketches in figure 2 that the matter of malignancy, and especially that of malignant infiltration, must govern in the handling of any bladder tumor. The so-called benign papilloma represented in the first view can be destroyed nicely by transurethral electrocoagulation. Simple destruction of the protruding part of the second tumor, however, would be obviously inadequate. And in the type of tumor

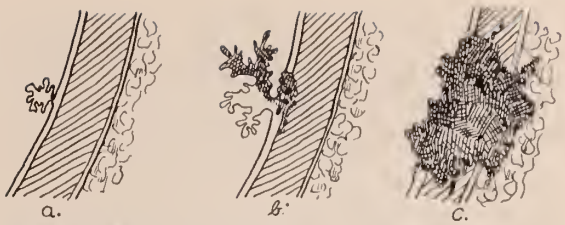

Fig. 2.—Schematic drawings representing (a) benign papilloma, (b) malignant papilloma with early bladder wall invasion, and (c) deeply invasive infiltrating carcinoma.

indicated in the third view, anything short of radical surgical treatment would be palpably futile.

The question of remote metastasis must, if possible, be determined. And there are other less fundamental but none the less practical matters to be considered. The mere location of the bladder tumor may determine to a large extent its curability. A large infiltrating cancer in the dome of the bladder is often curable simply by excising the top half of the bladder, taking with it a wide margin of normal bladder wall. On the other hand, a relatively small cancer infiltrating deeply into the muscularis at the bladder neck demands the somewhat more dangerous and very mutilating procedure of total cystectomy—prostate, seminal vesicles, bladder, and all—not to mention the added procedure of ureterosigmoidostomy or skin ureterostomy to provide for the future egress of urine. And since most bladder tumors occur near one or the other ureteral orifice, it becomes necessary to study the upper urinary tract to determine the degree of renal damage that has occurred from strangulation of the lower ureter as it passes through the cancerous growth.

Much information concerning the degree of malignancy can be had from careful cystoscopic study of the gross appearance of a bladder tumor. Practically all low-lying, broad-based tumors—whether ulcerative or not—are of relatively high malignancy and deeply invasive. Especially if ulceration and encrustation is present or if areas of leukoplakia within the bladder suggest a tumor to have elements of metaplastic squamous epithelium they are certain to be highly malignant.

The papillary tumors vary widely in their malignancy. In general the smaller the tumor, the more delicate its frons, and the more narrow its pedicle, the less malignant it will be found to be. Aside from these general characteristics there are three other matters to be carefully observed in the cystoscopic study of tumors, each of which gives much information as to their malignancy. Tumors that are multiple, whatever their cellular structure may be, are likely to recur and in a clinical sense are more malignant simply because of their multiplicity. Areas of ulceration and encrustation mark a papillary tumor as being malignant. And any material increase in vascularity with elevation of the mucosa surrounding the pedicle of a papillary tumor always suggests submucous infiltration marking the tumor both malignant and highly invasive.

All bladder tumors are malignant. Even the simple papilloma with delicate frons, a small pedicle, completely innocent cellular structure, and no invasiveness whatever is a potentially malignant tumor. However innocent it may appear, it tends to spread or implant itself elsewhere within the bladder, and, once destroyed, it tends to recur. It is this tendency for papillary tumors to recur that makes cystoscopy so important every six months or year after removing the original tumor—that, together with the possibility that a recurrence, however innocent it may at first be, might undergo truly malignant changes before symptoms appeared to announce its presence. Destruction of small benign papillomas of this sort ordinarily is a very simple matter. With a bit of fortitude on the patient's part, they often can be coagulated through the cystoscope as a simple office procedure. It were far better, however, that such a patient be hospitalized and anesthetized to permit removal by a clean cut with the loop of the resectoscope and proper coagulation of the area of the bladder wall from which the tumor has sprung. There is more finality to such a procedure, and, besides, it has the added advantage of furnishing biopsy material to check against the occasional case of real malignancy in a small tumor of disarming appearance.

I am certain our pathologists will bless me for showing figure 3. Its message, of course, has to do with the collection of proper material for biopsy of a bladder tumor. Like most schematic drawings it oversimplifies matters somewhat. Yet it is perfectly true that the story the pathologist reads from the cellular structure of a section of bladder tumor can vary considerably depending upon the location from

Fig. 3.—Indicating the varying information gained from different areas of a papillary tumor undergoing malignant degeneration.

which the section is taken. There are tumors sufficiently malignant to lead to early death, having areas such as "A," which any pathologist would grade very low in the scale of malignancy. A section taken through the stalk of the tumor at "B," however, would disclose substantial evidence of malignancy. And a section taken at "C" by including bladder wall tissue would add the significant fact that the tumor is highly invasive and the more dangerous.

This same figure 3 will serve well to illustrate the clinical problem that is presented by a true papillary carcinoma of the urinary bladder. They can vary in size from that of a pea to that of a hen's egg and still fall within the architectural pattern that this sketch portrays. There is no problem in all urology that is so confusing and so challenging as that presented by a tumor of this type. If the tumor lies high in the bladder vault the answer is fairly simple. Subtotal resection of the tumor-bearing area then can be radical and still leave the urinary system intact. Unfortunately, however, most tumors occur at the bladder base near one of the three important orifices, and anything like adequate surgical treatment becomes a difficult and mutilating affair. As the years pass I find myself growing more bold with this type of tumor. Yet, when invasion is not palpably deep within the bladder wall and when adequate open operation necessitates sidetracking the urine from one or both kidneys, my inclination still lies on the side of transurethral resection of this type of tumor. After all, it is possible to be quite radical with the cutting loop of the resectoscope. A substantial number of tumors of this type can be cured by bold resection providing there is minimal invasion of the submucosa. And the immense gratification of having left one with his urinary apparatus to function normally is too great to be taken lightly. To be at all thorough and effective in the transurethral removal of an infiltrating bladder tumor, one cannot rest with destruction of the intravesical mass and brushing the base with the coagulating current. Cure of such a cancer necessarily must involve complete destruction, both in depth and in breadth, of all of the bladder wall harboring cancer cells. Nearly the entire thickness of the bladder wall must be cut away with the wire loop, and the cutting must be carried widely beyond the evident margins of the tumor. That calls for a high degree of courage and dexterity. The risks, however, are not forbidding if one leaves for open surgical treatment those tumors of that part of the bladder dome that is covered by peritoneum and limits transurethral excision to those areas of the bladder wall that are solidly fixed in the surrounding pelvic structures. Even deliberate full thickness resection of a sizable area of the fixed bladder wall usually can be accomplished with complete hemostasis, and a week or two of careful postoperative catheter drainage will ordinarily suffice to prevent perivesicular extravasation of urine. In those few cases in which bleeding gets out of bounds or urinary extravasation occurs requiring secondary suprapubic exposure, the procedure still has the advantages of having permitted destruction of the tumor under far better visualization than in the opened bladder and of escaping

much of the danger of planting uncooked and viable tumor cells into the fresh cut tissues of the cystotomy wound. Incidentally, neither the proximity of one of the ureteral orifices nor the internal urinary meatus requires particular consideration in resecting a bladder tumor. If they are cut clean with the wire loop and not too heavily coagulated, their lumen will re-establish nicely and without stricture.

Despite all the worth that lies in the transurethral management of bladder tumors, there are certain types and degrees of bladder cancer that are completely beyond any such conservative means. A certain small percentage of bladder cancers begin as highly invasive, low lying, and rapidly ulcerating lesions. To whittle away and cook such a tumor is but to scratch its surface. With cancerous invasion extending deep into the bladder wall and beyond, nothing in the way of surgical treatment short of complete and clean excision of the entire lesion can hold the slightest promise of cure. If tumor cells have reached the regional lymph nodes they, too, must be removed by block dissection. And if the tumor has extended beyond the regional lymph glands, there can be no hope whatever of cure.

Perhaps it is well to digress at this point and mention the fact, both interesting and of enormous import, that bladder cancers are comparatively slow to metastasize. Indeed, it is the rule rather than the exception for a pathologist to examine the body of one dead of bladder cancer without being able to demonstrate metastatic lesions, death having occurred from a combination of uremia and sepsis the result of obstruction from malignant infiltration of the lower ureters or the bladder neck. For cancer thus to cause death without the advent of remote metastasis is a circumstance quite unique in tumor pathology. It is this lag in the remote spread of cancer that is the basis upon which reasonable hope may be held for the cure of even advanced bladder cancer when circumstances permit of surgical treatment sufficiently radical to remove all of the local pathology.

In figure 4 (case 1) one sees a highly malignant, highly invasive cancer that happened to develop in the bladder dome. Peritoneum overlying some of its outer surface was puckered and thickened in testimony of the complete cancerous penetration of the bladder wall. This elderly woman patient hardly had more than the edges of her trigon left to sew into a sort of bladder around the head of a Pezzar catheter. Yet she lived for years, and died with a normal bladder—not alone free from tumor but normal in size and capacity. The curability of advanced bladder cancer is sometimes surprising, and the power of regeneration of the bladder wall is always amazing!

For the moment let us assume that in figure 5 (case 2) there had been but the one large tumor seen in the bladder dome. The second small tumor near the internal urethral orifice made it too much

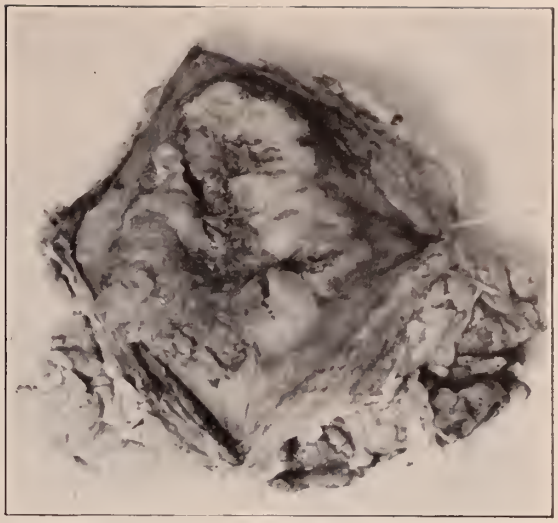

Fig. 4 (Case 1).—Infiltrating carcinoma of the bladder dome removed by subtotal cystectomy.

to hope for a cure short of total cystectomy, and that is what was done. But let us assume that only the large lesion in the bladder dome was present. Like the flat infiltrating lesion in case 1, the tumor was in an ideal spot for complete excision. Both were deeply invasive. Both were of a cellular structure indicating a high degree of malignancy—grade IV in the infiltrating tumor and grade III in this papillary tumor. Despite the slightly more favorable cellular picture, however, the prognosis in wide excision of the bladder dome in this case would be less favorable than in case 1. The reasons are both interesting and important. In neither is remote metastasis particularly likely to have developed. We have already said that bladder tumors are slow to jump to distant regions, and that fact becomes increasingly true as the tumor is found farther and farther from the bladder neck. But the papillary tumor is far, far more liable to metastasize within the bladder itself. Indeed, it already has done it! Whether through tissue predilection, by submucous lymphatic extension, or by actual cell implantation, papillary tumors tend to spread and multiply within the urinary bladder. And that clinical fact increases their malignancy, whatever their cellular structure may be.

There is a second reason why the papillary tumor of the bladder dome would be more likely to kill than the infiltrating tumor if segmental resection of the tumor-bearing area of the bladder wall were to be the surgical procedure to be employed. Tumor cells will readily implant and grow in fresh cut tissue, and this is particularly true of the cells from papillary bladder tumors. There is nothing quite so disheartening as to see this sort of implantation metastasis in the belly wall after having opened a bladder to excise or destroy a papillary tumor (case 3). The danger of this implantation metastasis is just great enough to make one always hesi-

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Fig. 5 (case 2).—First view shows the opened bladder and prostate, the entire bladder together with the prostate and seminal vesicles having been removed in a single mass. Second view shows the bladder everted with the large parent tumor in the vault and a smaller secondary tumor near the internal urethral orifice.

tate before attempting destruction of a papillary bladder tumor by open surgical treatment. It were far better, if a tumor can be adequately destroyed by electrocoagulation, that it be done transurethrally. And when I do have occasion to open a bladder containing a papillary tumor, I am just old fashioned enough to want to slush out the bladder cavity and the soft tissues of the prevesical space and belly wall with a can of ether. I have no figures to show that it reduces materially the likelihood of this sort of tragic implantation metastasis, but I do recognize the danger and I always have an abiding hope that ether will make some difference in the viability of fragmented tumor cells.

Fig. 6 (Case 3).—Massive implantation cancer in a cystotomy wound after open destruction of a papillary bladder tumor.

While the majority of papillary bladder tumors can be best managed by transurethral methods or segmental bladder resection, there are certain types in which nothing in the way of surgical attack could be considered at all adequate short of total extirpation of the entire tumor-bearing organ. This is true in relatively benign tumors that recur with great persistence or when, as in case 4, they grow rapidly and are distributed widely over the entire bladder surface. This bladder has been inverted for photography, and one can readily appreciate the extent to which its cavity was packed by the mass of papillomatous tissues.

Any tumor on the bladder base that is sufficiently invasive as to present palpable induration on rectal examination is certainly beyond the possibility of surgical cure except by total cystectomy. When this finding is to be taken as a guide to proper surgical treatment, however, palpation must be done under the muscular relaxation of a general anesthetic. Not infrequently an invasive tumor near one or the other ureteral orifice, entirely beyond the reach of a palpating finger, can be caught bimanually under anesthesia and its zone of intramural induration clearly outlined. Once intramural or pericystic invasion is clearly palpable, radical cystectomy is the only surgical procedure that could possibly promise hope of cure.

Fig. 7 (case 4).—Cystectomized bladder inverted to show the mass of papillary tumor tissue that completely filled its cavity.

Comparatively rare though it may be, I cannot refrain from making mention of the occasional occurrence of bladder tumor as a secondary lesion metastatic from a parent papillary tumor of the renal pelvis. Two years before, the patient in case 5 had had a nephrectomy elsewhere for renal tumor. Its exact nature is not known, but with papillomatous lesions in the stump of the ureter and others within the bladder it is a safe assumption that the renal tumor was a papillary carcinoma. In any event the slide serves to illustrate the importance of removal of the entire ureter and making careful cystoscopic study for possible bladder transplants whenever nephrectomy is done for a papillary tumor of the renal pelvis.

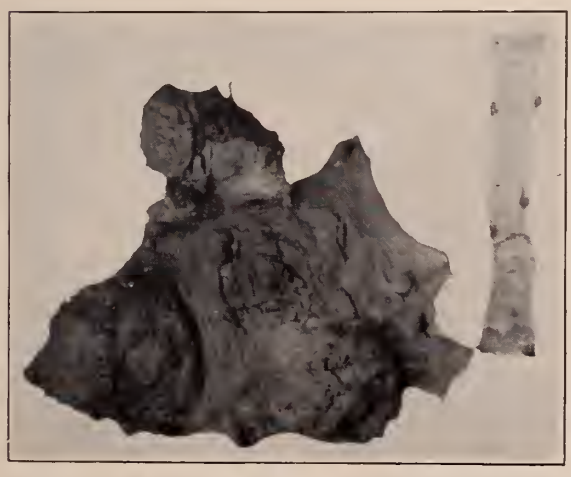

Fig. 8 (case 5).—Cystoureterectomy for implantation papillary carcinomas in ureteral stump and bladder following nephrectomy for renal tumor.

Until quite recently total cystectomy was too formidable a procedure to be undertaken by most surgeons and then only as a last resort. The procedure was made doubly complicated and difficult by having to divert the urinary stream either to the skin surface or to the lower bowel—the former a most disagreeable inconvenience to the patient and the latter fraught with many disturbing renal complications. Moreover, local recurrence in the stump of the prostatic urethra or body of the prostate and seminal vesicles soon pointed to the added necessity of complete extirpation of these organs together with the bladder specimen. And finally, hemorrhage and shock were formidable deterrents to such radical surgical treatment in patients at all debilitated or well along in years.

Thanks to one of the great lessons of the recent war, however, whole blood has come to be almost routine during heavy surgical procedures of this sort. Nowadays with 2 or 3 pints of whole blood given before and during operation a patient leaves the operating table in excellent condition despite a blood loss that in prior years would have been considered prohibitive. Anesthesia has been improved immensely and one or two hours in the operating room no longer is an important factor mitigating against radical operations of this type. Moreover ureterointestinal anastamosis has come to be highly successful through proper preoperative bowel preparation and the generous use of the antibiotics, both of which have combined to minimize the inflammatory reaction at the seat of the anastamosis and render the several accepted types of procedure quite uniformly successful. Through these several circumstances cystectomy combined with bilateral ureterosigmoidostomy is coming to be done more and more commonly as a one stage procedure.

The final answer to the successful treatment of bladder cancer has not yet been written. Surely at some future time an all-merciful Providence will put into our hands some new biochemical development or some physical modality that will permit this dread disease to be more simply and certainly controlled. There are new stirrings both in the field of radiation physics and in the field of hormonal chemistry that give great promise, not to mention the unknown and apparently vast possibilities that lie in the field of atomic energy. Until then, however, surgical treatment in one form or other will continue the greatest refuge for those with bladder tumor. And as in cancer of the breast, the bowel, and elsewhere, the surgical treatment of cancer of the bladder will doubtless reach its fullest development only on that day when better diagnosis, improved surgical technic, and dauntless courage combine to make us all quick to recognize, prompt to proceed, and completely bold and devastating in our attack.

Strangulated Inguinal Hernia in a Man of 88 Years

Operation and Recovery

By V. S. FALK, JR., M. D.
Edgerton

V. S. FALK

Following graduation from the University of Wisconsin Medical School in 1939, Doctor Falk interned at Aucker Hospital in St. Paul. During 1940-1941 he served a residency in surgery at the Carle Hospital Clinic in Urbana, Illinois and the following year he entered the United States Navy. He was discharged in 1943 with the rank of commander. Prior to his joining the Shearer Clinic in Edgerton, he completed his residency in surgery at the Augustana Hospital in Chicago.

THIS is a report of a successful operation for a strangulated inguinal hernia in a man, aged 88. It is being reported because of the advanced age of the patient, because surgery in geriatrics is becoming more common as man's span of life is increasing, and as a contention that age alone is no contraindication to surgical intervention.

The subject of strangulated hernia in the aged is indeed an old one. Bowes[1] in 1898 reported a case of strangulated umbilical hernia in a man of 89 who was successfully operated on without the use of general anesthetic. This article is of historic interest, as the operation was performed by candle light, and the postoperative care consisted of brandy by mouth, meat suppositories, and nutrient injections per rectum. In 1903 Mac Laurin[2] wrote concerning the frequency and treatment of strangulated hernia in the aged. He stated that strangulation was essentially a disease of people advanced in years and that the mortality was largely among the elderly poor. The death rate for this condition in people over 50 at that time was 27 per cent. Even then he emphasized that prolonged attempts at reduction courted disaster and that "modern writers agree in stating that about one minute is quite long enough to try."

A comprehensive article on the treatment of strangulated hernia in the very old was written by Peyton[3] in 1905. He too stressed the dangers of taxis as only further injuring an already weakened and damaged intestine and consuming time which might be used to save the patient's life by earlier surgical treatment. Taxis may also be the means of reducing the hernia *en masse* without relieving the strangulation. (I observed this situation while on the service of Dr. N. M. Percy at the Augustana Hospital in Chicago in 1947. Doctor Percy operated on an elderly man whose strangulated femoral hernia had been reduced *en masse* by taxis resulting in intestinal obstruction. Doctor Percy stated that he had been looking for this phenomena during his fifty years of surgical experience and that this was the first time he had encountered it.) Other principles set forth by Peyton are still equally good. He believed that all patients suffering from hernia should be plainly advised to submit to operation for radical cure, since practically all hernias sooner or later become strangulated. He also advocated early operation to avoid the disastrous results of gangrenous changes in the involved viscera, to allow the use of a minimum of general anesthesia in the aged patient, and further to permit early ambulation. (This was in 1905.) He reported the case of a patient aged 84, whose extreme age caused him to write to other leading surgeons of that day asking for their upper age limits in successfully operated strangulated hernias. All the men he contacted agreed that advanced age was no bar to successful operation for strangulated hernia. The surgeons reported the ages of their eldest patients from 66 to 95 years. The 95 year old patient lived for three years after operation. In another article, written in 1905, Holden[4] reported a case of a strangulated femoral hernia in a woman of 94, who was successfully operated on using chloroform anesthesia. Field's[5] article in 1921 stated that in the presence of strangulated hernia, especially in the aged, local anesthesia is imperative. He reported 4 cases, and it is of interest to note that strangulation had been present for two, three, or four days before operation and that all recovered uneventfully despite the dark color of the strangulated loop of bowel. One of his patients, a 90 year old woman, went home four days after operation for a strangulated femoral hernia.

Corlette[6] reported a case with operation and recovery of a strangulated inguinal hernia with "burst sac" in a patient 90 years of age. In 1939 Clagett[7] presented a series of 8 cases in which operations were performed at the Mayo Clinic for strangulated hernia in patients more than 70 years of age. In this group 2 were women and 6 were men; there were three femoral and five inguinal hernias. Their ages ranged from 70 to 86. Local anesthesia, sometimes supplemented by intravenous sodium pentothal, was most frequently used. There was one death in this series, occurring in a man of 70 whose hernia had been strangulated for forty-eight hours.

Because successful operations for strangulated hernias in the very aged are of such interest to the

surgical profession, I am reporting this case of a strangulated inguinal hernia which was successfully operated on by me in a man of 88 years. The history of his case follows.

Mr. J. P., an 88 year old white male, was admitted to the Edgerton Memorial Hospital as an emergency on Feb. 21, 1948 with the chief complaint of "pain in the lower left side." In this patient, who was single and a retired farmer, and who had outlived all of his siblings except two much younger brothers, a hernia had first developed sixteen years previously. He had had a surgical repair done twelve years before, but two weeks following the operation he had fallen, and the hernia recurred. It had become larger and more difficult to control as time passed. During the past year he had been bedridden most of the time because whenever he was up the hernial contents descended into the scrotum. On two occasions during the past year he had been unable to reduce the hernia, but his family physician had done so by taxis without difficulty. About two and one half hours prior to admission, the patient had arisen from bed to defecate, and the hernia "dropped down as usual." He again was unable to reduce it. His family physician saw him an hour later, and he too was unsuccessful in his attempt to reduce it. Because of this and the associated pain, the patient was admitted to the hospital for treatment. There was no nausea or vomiting.

A review of the patient's history by systems revealed the following pertinent findings: 1. Twenty-five years before he had been diagnosed as having a "bad heart." For four years prior to admission he had had dyspnea and cyanosis on slight exertion. He had also had "asthma" for seven years and a productive cough for ten years. 2. Prostatic resection had been done twelve years previously. Nocturia was now present (once or twice). 3. He had severe arthritis of the upper extremities of two years' duration.

Physical Examination.—The patient was a well developed, gaunt male of 88 in severe pain. His temperature was 98.8 F., the pulse rate 112 and totally irregular, and the blood pressure 120/72. There were coarse rales scattered throughout the chest. The heart was moderately enlarged to the left and was fibrillating. The vessels were generally sclerotic. On examination of the abdomen there was a firm, tense, ovoid mass 8 by 4 inches in the left inguinal area, extending well into the scrotum. This herniated mass was irreducible. The elbows were fixed in 30 degree flexion. The fingers and hands were markedly enlarged, and motion was limited due to arthritic changes.

Laboratory Findings.—The hemoglobin was 60 per cent, and white blood cell count 10,300. The Wassermann reaction was negative. Urinalysis was negative except for 2 or 3 pus cells per high power field .

In view of the history and the findings of an irreducible tender inguinal mass, and because of an elevation of pulse rate and white blood cell count, the diagnosis of a strangulated left indirect inguinal hernia was made. With this diagnosis, immediate operation was imperative in spite of the age and generally poor condition of the patient.

Operative Record.—The operation was begun about four hours after the hernia strangulated. The left inguinal area was infiltrated with 1 per cent Novocaine solution. An oblique incision was made over the mass. More Novocaine was injected, and the incision extended through the external oblique aponeurosis. At this point the patient was so uncomfortable that a general anesthetic (nitrous oxide, oxygen and ether in a closed system) was begun. The hernial sac was fairly thick walled. It was freed up and opened. The contents were not adherent to the sac, and, as a result, part of the contents returned to the peritoneal cavity when the constricting ring at the neck of the sac was sectioned. The remaining contents consisted of a loop of bowel, deep purple in color, quite friable but having some sheen. There was a large amount of dark red, watery, malodorous fluid in the sac. This was sponged out. The color of the bowel improved with the use of warm compresses. After it was seen that the bowel was definitely viable, it was returned to the peritoneal cavity. The sac was then ligated at the neck, using a doubled 00 chromic suture, and the excess sac was excised. This same suture was carried through the internal oblique muscle, from within out, to transfix the stump of the sac under this muscle. The testicle was not disturbed, because of the patient's poor condition, and the cord was left in its bed. A Ferguson type repair was made by suturing the internal oblique muscle and its conjoined tendon to Poupart's ligament with interrupted doubled 00 chromic. The aponeurosis of the external oblique muscle was closed, using the same type of sutures. The skin was closed with interrupted silk.

Postoperative Course.—The operation was completed in twenty minutes. The patient was returned to his room in rather poor condition. He was given 1,000 cc of 5 per cent glucose in water with 2 units of digitalis very slowly intravenously. On the first postoperative day he had one emesis, had trouble swallowing because of his asthma, and was given another liter of 5 per cent glucose in water intravenously with digitalis. Procaine-penicillin in oil, 1 cc. (300,000 units), was given daily intramuscularly. Infusions of 5 per cent glucose in water were given on the following two days. On the third day he passed some gas. His only complaint was of the arthritis in his arms. On the fourth day he sat on the edge of the bed to eat, and he was up in a chair the following morning. On the sixth day he was given an enema, with good results. On the seventh day the skin sutures were removed and the wound was clean, dry, and well healed. The next day his pulse was regular, and he passed a large stool. From then on he was walking some every day, more than he had done at home in the previous year, and was eating well. He stayed in the hospital three weeks and was discharged on 1 unit of digitalis daily at home. The patient had absolutely no further trouble from his former hernia.

Summary

A case of a successfully operated strangulated recurrent inguinal hernia in a man of 88 in poor physical condition is presented. The literature on the subject of strangulated hernia in the aged has been reviewed. Surgical treatment in the aged is becoming more prevalent (e.g., I recently performed a bilateral inguinal herniorrhapy on an active man of 81 who was not satisfied with his trusses) and certainly is mandatory in cases of strangulated hernias. While preparing this paper, I also operated on a man, aged 72, for a strangulated recurrent direct inguinal hernia. Since he was in good physical condition and had a large hydrocele on the same side as the hernia, the testicle and hydrocele were removed through the inguinal incision, thus permitting an even stronger repair.

Conclusions

1. Hernia repair should be recommended in all cases (in which there is no specific contraindication) at a reasonable age and before it becomes an emergency.

2. Prolonged taxis of a strangulated hernia should not be practiced.

3. Strangulated hernias should be operated on as soon as the diagnosis is established.

4. Local anesthesia should be used insofar as practicable.

5. Early ambulation is especially desirable in the aged.

6. Advanced age alone is certainly no contraindication to surgical intervention.

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Placenta Accreta*

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MORE women die from accidents of the third stage of labor than from those during the first and second stages combined. The woman's freedom from postpartum hemorrhage, her smooth convalescence during the puerperium, and her return to normal health depend to a great measure on the knowledge of the physiology and proper conduct of the so-called "placental stage." Its importance was recently emphasized in a discussion of postpartum hemorrhage by authorities who stated that, if a choice were necessary they would prefer to assume the responsibility for the conduct of the third stage of labor and delegate the care of the second stage to someone with less experience.

A perfect understanding is essential to recognize the occasional complications of placental separation, bearing in mind the two mechanisms involved, namely, separation and expulsion. The mechanics of this stage are well described by Brandt, who briefly states, "the diminishing size of the uterus with delivery results in extravasation of blood under tension in the decidua spongiosa. This causes tearing of the very fine septa of the spongiosa, thereby detaching the placenta from its uterine site. The subsequent uterine contractions acting on the increased bulk as on a hydraulic wedge, force the placenta down into the lower segment." Delivery is then effected by the continuing powers.

The problem of placental expulsion is a vital issue. The injudicious management of the third stage of labor with attempts at hasty delivery of the placenta usually results in varying degrees of unnecessary hemorrhage, trauma to the uterus, retention of the secundines, damage to the bladder, and even uterine inversion.

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The rarity of placenta accreta or increta does not preclude the abandonment of routine diligent patience when one is confronted by a situation in which the placenta does not deliver itself in short manner. It is probable that it does occur more often than suspected, since in some cases partial accreta is overlooked. At the present time, 177 authentic cases of complete accreta have been reported. Greenhill believes that it does occur in at least every 2,000 cases if all types are accounted for.

By definition, placenta accreta is an abnormal fusion of the entire or part of the placenta to the uterine wall where partial or complete absence of the decidua basalis has been effected. We may say, further, that it is not only an abnormality of implantation, but also one of separation. Schumann has suggested that the syncytial cells are possessed of an abnormal power of erosion and penetration, and that they digest and perforate a normal decidua, continuing their erosive activity until they deeply penetrate the uterine muscle. Whether or not the absence of normal continuity of the endometrium due to trauma, infection, endocrine therapy, or imbalance potentiated this characteristic to a greater or abnormal degree, or whether the residual scarring is a prime factor in the causation, is a point to argue. We cannot dispute, however, that, although the placenta is a benign organ, it does, by its very development, possess malignant characteristics.

Placenta accreta is an extremely serious complication because of the attending danger of profuse hemorrhage or severe infection following attempts at manual removal of the adherent and retained organ. It is at this point that the diagnosis is usually made. Upon invasion of the uterine cavity, the placenta will be found to be so firmly attached to the uterine wall that there will be no distinguishable line of cleavage between the two.

Statistics reveal that there is a marked decline in the rate of mortality when hysterectomy is resorted to as soon as the diagnosis is made. Further, supravaginal hysterectomy is more favorable than vaginal removal. There have been instances reported in which the placenta was allowed to remain and absorption followed without any unfavorable results. Nevertheless, it is far less heroic to operate even though the uterus has been invaded and the risk of infection high.

We submit a case of complete placenta accreta which typically follows the pattern as described by others. It is interesting to note, moreover, in conjunction with an abnormal placenta, we found developmental defects in the delivered infant.

Mrs. K. B., aged 30, a gravida V para IV, was admitted to Mount Sinai Hospital, Milwaukee, on March 11, 1947, with questionable ruptured membranes. Forty-eight hours prior to time of admission, the patient claimed the membranes ruptured spontaneously. She was seen the day of admission by the attending physician and immediately hospitalized.

History—The menarche was at 13 years. The cycle was irregular, bleeding occurring every twenty-one to twenty-eight days. The flow was profuse, and severe dysmenorrhea was present during the first twenty-four hours. There was no history of metrorrhagia, and the patient denied venereal disease.

Previous pregnancies were as follows: (1) at age 16, full term delivery (infant living and well); (2) at age 18, full term delivery (infant died at 2½ years, of pertussis and bronchopneumonia); (3) at age 20, full term delivery (stillbirth); and (4) at age 21½, premature delivery (8 months) (infant lived twenty-four days). The patient admitted submitting to many illegal abortions but would not account for the exact number.

The last known menstrual period was June 2, 1946. The expected date of confinement was March 9, 1947. Physical examination was essentially negative. The temperature was 98.6 F. Abdominal examination revealed a full term pregnancy, vertex presenting. Because of the contour of the uterus and the resiliency to touch, it was believed that the membranes were still intact. There was no dilatation, and the presenting part was floating. Fetal heart tones were distinct and regular. Six hours after admission, the patient was discharged from the hospital with a diagnosis of false labor, membranes intact. The patient was re-admitted to the hospital on March 15, 1947. The temperature was 99.2 F., pulse rate 80, and respiratory rate 20. A small amount of yellowish vaginal discharge was noted on examination. There were no uterine contractions and no dilatation of the cervix, and the presenting part was floating. Labor was successfully induced by medical means after twenty-four hours of hospitalization. After five and one-half hours of active labor, delivery of a living female infant with bilateral harelip and cleft palate was effected. Delivery was by low forceps under general anesthesia. When delivery of the placenta failed to occur after thirty minutes, Adrenalin (10 minims) was administered by hypodermic. Attempts to deliver the placenta by Brandt expression were unsuccessful. Three hours later, with no vaginal bleeding present and no signs of placental separation, the patient was returned to the labor room, where she could be observed closely for hemorrhage. Temperature, pulse, and respirations were as previously noted. Eight hours later, the patient had a mild chill. The temperature rose to 101.6 F., the pulse rate was 76, and respiratory rate 20, and there was still no evidence of internal or external bleeding. Two and one-half hours later, or thirteen and one-half hours after delivery, the patient was surgically prepared and the uterine cavity was explored. As no line of cleavage between the placenta and the uterine wall was found, a diagnosis of placenta accreta was made, and a supravaginal hysterectomy was performed immediately. The patient made an uneventful postoperative recovery.

Pathologic Report (Dr. N. Enzer).—Gross examination revealed a supravaginally amputated gravid uterus measuring 14 cm. transversely and 17 cm. long. The myometrium measured up to 4 cm. Closely adherent to the entire fundus and extending to the internal os was a placenta measuring 17 cm. long. On cut surface, the maternal surface of the placenta did not present any gross abnormalities. Occasional small infarcts were seen.

Microscopic Examinations.—The sections showed a markedly thickened and edematous myometrium.

Fig. 1.—Low power magnification showing irregularly arranged chorionic villi with fibrous and hyaline stroma fused with myometrium.

The individual muscle cells showed decidual reaction. Closely adherent to the upper layers of the muscle was placental tissue with areas of focal infarction. Conspicuous was the complete absence of the spongy layer of the decidua as well as the bordering zone of the endometrium. The muscle fibers were directly beneath the chorionic villi and in many areas drawn up into the placental septae.

Pathologic Diagnosis.—The pathologic diagnosis was placenta accreta, complete.

Summary

When, after thirteen and one-half hours, no sign of placental separation or any bleeding had occurred, the possibility of placenta accreta was considered and confirmed by intrauterine digital exploration. A supravaginal hysterectomy was performed with uneventful recovery. While hysterectomy may seem a radical procedure, it is actually conservative in that the mortality rate is practically zero, while the sequelae of hemorrhage and infection following attempts at manual removal of the placenta result in a mortality rate of at least 60 per cent.

Fig. 2.—High power magnification showing sclerosing changes in chorionic villi. Fusion of chorionic epithelium, absence of decidual reaction, and intimate fusion with myometrium are demonstrated.

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The Management of the Surgical Diabetic Patient*

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Chief of staff of St. Joseph's Hospital in Marshfield, Doctor Baldwin is a graduate of the University of Chicago and Rush Medical College. He completed his internship and a residency at Cook County Hospital and Presbyterian Hospital in Chicago. In addition to his work at St. Joseph's Hospital, the doctor also serves on the staff of Marshfield Clinic.

DIABETES creates special problems for the surgeon and internist by predisposing the patient to the infectious and degenerative diseases and by imposing the management of the diabetic state on the surgical regimen. The control of the carbohydrate metabolism must be continued through a time when diagnostic studies, as well as anesthesia and surgery, alter the conditions of physiology.

During the period of preparation the diabetes is regulated and the patient is studied. The two-fold purpose of this period is, first, to put him in the best possible condition for operation and, second, to learn how his sugar metabolism functions so the postoperative program will keep him out of danger from acidosis, on the one hand, and from hypoglycemic reactions, on the other. Insulin shock is particularly undesirable in a person who has had a cataract operation.

One wants to be sure of his diagnosis of diabetes and to determine its severity and type. One must know the patient's insulin requirement, how sensitive he is to variations in insulin dose, and what time of the day he spills the most sugar in his urine. We like to know how he will adjust to prolonged recumbency and about his dietary habits and food idiosyncrasies. We would not want to put a person allergic to milk on a liquid diet containing only milk.

One must know whether any restrictions are to be made and how to plan for them. Urine specimens in obstetric patients and those having surgical treatment of the lower urinary tract contain large amounts of blood. The patient may not be able to void, and frequent catheterization or indwelling catheters may be undesirable.

Selecting the proper time for surgical procedures in nonemergency patients calls for special consideration. Surgery may be necessary even in the presence of a diabetic state that is becoming worse. This sometimes happens in patients with gangrene or with deep abscesses.

The chief principle adhered to in managing the patient through his day of operation and the ones following is to maintain the patient's program without interruption or alteration. The diabetic needs food and insulin at regular intervals. This must continue throughout the surgical period with as little variation as possible. If the patient is on a diet which furnishes 225 G† and he takes 50 units of insulin, this is what he should have the day of operation and each day following, if he needs it. There should be no period of starvation.

For practical considerations, we modify the program somewhat and usually give 50 Gm. of glucose intravenously three times the day of operation, and for as many more days as necessary until the patient is able to take nourishment by mouth. When he is able to take his nourishment by mouth he is put on an emergency liquid diet, which consists either of 300 cc. of milk every three hours from 6 a. m. to 9 p. m., or orange juice, 200 cc. at the same hours. This is followed by the special light diabetic diet, which furnishes 160 Gm. of carbohydrate, 60 Gm. of protein and 60 Gm. of fat. As the patient improves in strength and appetite, he is advanced to a soft diet of the same formula and then he goes to the regular diet.

We prefer to have the patient operated on as early as possible in the morning. If the surgeons would do their work between midnight and 4:00 a. m., our purpose would best be served, because the operation could then proceed with practically no interruption in the patient's routine. This, we realize, is asking too much of the operating room personnel. It has been noted in many instances in which emergency surgical treatment has been necessitated during those hours, that the postoperative course is a very smooth one. A special request is made, however, that the operation be scheduled early in the morning. The patient does better if there is no preliminary period of starvation. If the surgical procedure is held off until 10:30 or 11 in the morning, the problem of regulation is made more complicated.

This is the routine for the average patient. For those with mild diabetes not requiring insulin, no special measures are instituted the day of opera-

* Presented before the annual meeting of the Wisconsin Surgical Society, Marshfield, May 15, 1948.

† G, the glucose equivalent of the diet is 100 per cent of the carbohydrate, 58 per cent of the protein and 10 per cent of the fat.

tion. The urine specimens are carefully tested at frequent intervals, so proper measures can be immediately taken in case marked glycosuria appears. Patients who have operations about the mouth or jaws and cataract cases, in which chewing is undesirable for several days, are put on the full liquid diabetic diet on the second day after the operation. This diet furnishes the same dietary formula as his regular diet. Patients who have had their jaws wired and are fed through a tube can be maintained for an indefinite period on such a diet, without any impairment of their nutrition.

Emergency operations call for special handling. If the patient is in acidosis, the administration of fluids and insulin are begun immediately and the progress of the case followed closely with urine tests every hour and blood sugar tests when necessary. Insulin, fluids, and glucose are given as indicated. The golden rule for managing a diabetic patient in danger is hourly observations.

Among the 113 diabetic patients admitted to St. Joseph's Hospital in 1947 were 145 admissions. Thirty-six of these patients had a total of forty-three operations. One patient had three operations, and 5 others had two operations each. The average age of the women was 57.5, and the average age of the men 65.8 years. Twenty-four of the 30 women were over 50 years of age; the 6 men were all 59 years of age or older. The data are summarized in table 1.

TABLE 1.—*Diabetes at St. Joseph's Hospital in 1947*

	Age	*F*	*M*
113 patients with diabetes	20–30	1	0
145 admissions with diabetes	30–40	2	0
36 surgical diabetic patients	40–50	3	0
43 operations (2 deliveries)	50–60	10	1
	60–70	9	3
	70–	5	2
		30	6
Average Age		57.5	65.8

The 43 operations classified according to pathology are shown in table 2.

TABLE 2.—*Type of Surgery*

Orthopedics		8
Amputation of leg	2	
Casts and manipulation of fracture	3	
Amputation of toes	2	
Removal of hip spike	1	
Infections—Incision and drainage of abscess		6
EENT		7
Cataract	5	
Mastoidectomy	1	
Enucleation of eye	1	
Gynecology and obstetrics		9
Hysterectomy	3	
Plastic on vagina	1	
Mastectomy	1	
Radium insertion of uterus	1	
Cervical polyp	1	
Pregnancy at term	2	
Genitourinary		5
Circumcision	1	
Cystoscopy	1	
Nephrectomy	1	
Prostatic Resection	1	
Dilatation of urethra	1	
Gastrointestinal		5
Cholecystectomy	3	
Teeth extraction	1	
Appendectomy	1	
Thyroidectomy		2
Excision of mole on face		1

One death occurred. The patient, besides diabetes, had pernicious anemia with subacute combined degeneration of the cord, multiple abscesses of both legs, empyema, and pulmonary abscesses. One of her feet had been transformed into a sloughing, necrotic mass. The amputation was done as a purely palliative measure. She died fourteen days after the operation. Three other patients died several months after leaving the hospital, from stroke, cardiac decompensation, and uremia.

Among our group of now over 700 diabetic patients, the problem of pregnancy has been particularly difficult. I would like to report on our experiences with these patients. The data are summarized in table 3.

TABLE 3.—*Pregnancies*

	1934–40	*1945–48*	*Total*
Number of pregnancies (No. of patients)	17 (9)	7 (7)	24 (14)
Full term (infant deaths)	14 (4)	6	20 (4)
Miscarriages and premature (1)	3	1	4
Normal deliveries (infant deaths)	11 (4)	3	14 (4)
Cesarean section	3	3	6

A total of 14 patients have had 24 pregnancies, one of which was a twin pregnancy.

Nine of the patients were seen prior to the war. Among them were seventeen pregnancies, fourteen of which were full term, with two miscarriages and one premature delivery. Ten of the full term pregnancies were successful, 4 were unsuccessful. Of the 4 full term infants that died, 1 was stillborn, 2 lived five days, and 1 died at 18 months. Three of the 17 were delivered by cesarean section. All of the children lived. Eleven were delivered from below.

Seven obstetric patients have been seen since the war. In 6 the deliveries were at full term (the children are living and well); 3 were delivered by cesarean section, and 3 were delivered spontaneously from below. One ended in a miscarriage at about three months.

In managing the obstetric patient with glycosuria, the first consideration is a proper diagnosis. Many of the patients have renal glycosuria of pregnancy rather than true diabetes. They will repeatedly show varying amounts of sugar in the urine, but the blood sugars are at all times normal. Lactose, which reduces copper sulfate, sometimes appears in the urine during the last trimester. The fermentation test is a simple procedure to rule this out. Occasionally we see patients with a combination of glycosuria of pregnancy and true diabetes.

The diabetes must be carefully guided throughout the course of pregnancy. In the latter months the insulin requirement may increase or it may decrease or it may stay the same. It is especially important to obtain repeated blood sugars in the last trimester if increasing amounts of glycosuria are observed, to make sure this is not due to lactose or to a lowered renal threshold.

The incidence of toxemias of pregnancy is much greater among diabetic women than among nondiabetic women. The work of Priscilla White[1] and her group in Boston has shown that, with the administration of large doses of estrogenic substances, the incidence of toxemias can be greatly lowered. We routinely give 10 mg. of progestin and 10 mg. of stilbestrol each day, starting with the fifth month.

Primiparas and patients who have previously been delivered by cesarean sections are delivered by cesarean section at the thirty-sixth week. The babies of diabetic mothers, if allowed to go to term, almost always are very large. In multiparas previously delivered from below, labor is induced at the thirty-sixth week if circumstances are favorable, and delivery is made through the birth canal. The immediate postoperative or postdelivery period is a critical one for the mother, as rapid changes often take place in the severity of her diabetic state. In most instances we have noticed a marked transient improvement in the diabetes. Some patients previously requiring 40 or 50 units of insulin per day for control were well managed with a dose of 10 units or less for several days during the early postpartum period.

These, then, are the methods used at St. Joseph's Hospital for the management of the surgical diabetic patient, and the results of our work in 1947, together with a fourteen year survey of the problem of pregnancy and diabetes. No other condition in medicine calls for such close cooperation between the internist and surgeon. The duty of the internist is to make the patient safe for surgical treatment, so that the patient can obtain the maximum benefit from his operation. The duty of the surgeon is to do his work quickly and skillfully at a time when the patient is in the optimum condition for the procedure.

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NATIONAL FOUNDATION FOR INFANTILE PARALYSIS ANNOUNCES POSTGRADUATE FELLOWSHIPS

The National Foundation for Infantile Paralysis has announced that a limited number of research fellowships are available in virology, orthopedic surgery, pediatrics, epidemiology and neurology. These fellowships are intended to emphasize (1) advanced training in the basic sciences as they apply to the particular specialty and to research, and (2) experience in research, which need not be immediately related to poliomyelitis. Requirements for eligibility are an M. D. degree, or, when appropriate, a Ph.D. degree; presentation of an appropriate program of study and investigation; United States citizenship; and sound health, as attested by a physical examination.

Clinical fellowships are available to physicians who wish to prepare for eligibility for certification by the American Board of Physical Medicine. Eligibility requirements include graduation from a class A school of medicine; completion of a rotating internship of not less than one year in an approved hospital; license to practice medicine in one or more states; United States citizenship; sound health as attested by a physical examination and under 40 years of age.

Fellowships are also available to physicians for one year of postgraduate study leading to a Master of Public Health degree at a school of public health approved by the American Public Health Association. Requirements for eligibility include graduation from a class A school of medicine; completion of an internship of not less than one year in a hospital approved by the Council on Medical Education and Hospitals of the A.M.A.; license to practice medicine in one or more states; citizenship in the United States; and sound health as attested by a physical examination.

Application may be made to the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York, at any time during the year. Selection of candidates will be made on a competitive basis by committees composed of specialists in each field. Awards are based on the individual need of each applicant.

Acute Intestinal Obstruction in the Patient Over 60 Years

Review of 80 Cases

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ACUTE intestinal obstruction in the patient over 60 is a killer. Mortality rates in intestinal obstruction have dropped in the last fifteen years, but this drop is not as evident in the older age groups. Reviews of cases published in the last ten years showed the following mortality rates:

TABLE 1

Author	Number of Cases	Date	Mortality Rate, %
Dennis and Brown (University of Minnesota)[1] Small intestine	110	1943	15.5
Dennis[2] Large intestine	53	1944	15.1
McKittrick (Massachusetts General)[3]	136	1940	20.0
Scudder and Whipple[4]	2150	1938	19.0
Schlicke, Bargen, and Dixon (Mayo Clinic)[5] Conservative treatment	133	1940	21.8
Mayo, Miller, and Stalker[6]	136	1940	22.0
Morris and Johnson (Bellevue)[7] Strangulated hernia	130	1937	29.3
Calihan et al. (Johns Hopkins)[8]	204	1946	20.0

These seem to show that the present mortality rate in large series of intestinal obstruction is around 20 per cent. However, in these series, when the figures can be broken down by age groups, a much higher figure in the aged is found.

McIver[9] in 1932 reported a 61 per cent mortality in patients 60 to 70, 78 per cent in patients 70 to 80, and 100 per cent in patients over 80. Morris and Johnson in the series quoted above had 34 cases in which the patient was over 60 with a mortality rate of 47 per cent. McKittrick, in the series given in table 1, had 30 cases over 60 with a mortality rate of 67 per cent. In 1943 Dennis had a 30 per cent mortality rate in a series of patients in the 60 to 70 year old group.

In 1946 Calihan, Kennedy, and Blain reported a series of 23 patients from 60 to 80 years old, 9 of whom died, a mortality rate of 39 per cent.

Geriatrics is becoming an increasingly important part of medical practice as our population grows older. We believe that the generally better results in the treatment of intestinal obstruction tend to give us a false sense of security as far as patients in the older age group are concerned. In this paper we wish to review a group of 80 cases of acute intestinal obstruction in patients over 60 seen at the Jackson Clinic in the past twenty years. In all the cases the diagnosis of complete acute intestinal obstruction has been confirmed by surgery, autopsy, or definite x-ray findings.

Mortality must be considered from two aspects: death from the obstruction itself and death from complications.

Age groups, sex, and mortality are shown in table 2.

This shows a hospital mortality rate of 42.5 per cent for the 80 cases. However, 4 of our patients came in with acute obstruction, had the obstruction removed, and then became reobstructed, making a total of 76 patients. Thirty-four deaths in 76 patients gives us a corrected hospital patient mortality rate of 44.7 per cent. Twenty-three deaths were due to the obstruction itself and 11 from complications, making a mortality rate of 32 per cent, or 1 out of 3, due to obstruction.

TABLE 2

Age Group	Number in Group	Men	Women	Mortality from Obstruction		Mortality from Complications		Total Mortality	
				Number	%	Number	%	Number	%
60–69	43	24	19	12	28	4	9	16	37
70–79	27	18	9	8	30	5	18.5	13	48
80+	10	7	3	3	30	2	20	5	50
Total	80	49	31	23	29	11	14	34	42.5

One factor in the high mortality figures is the frequent presence of associated diseases which add to the risk of obstruction and lower the patient's resistance to this condition. Forty-five patients in the series had concurrent diseases. As would be expected, cardiovascular-renal disease, including hypertension, auricular fibrillation, arteriosclerosis, nephrosclerosis, myocardial enlargement, myocarditis, heart block, coronary disease, and cardiac decompensation, led the list, with 36 patients having some manifestation of this. Other diseases present included carcinoma of the stomach, bowel, and breast; prostatic disease; cystitis; urethrotrigonitis; chronic cholecystitis and cholelithiasis; arthritis; vaginal bleeding; degenerating ovarian cyst; senility; chronic uremia; obesity; esophageal diverticula; chronic thrombophlebitis; hernia; duodenal ulcer; and diverticulitis.

The presence in the series of obstruction caused by malignancy also added to the mortality.

Another factor lies in the apparent inability of elderly people to recover from consecutive operations. This will be discussed in greater detail.

In 25 patients postoperative complications developed, including pneumonia, thrombophlebitis, pulmonary embolism, reobstruction, coronary occlusion, cystitis, urethrotrigonitis, acute urinary retention, lung abscess, acute uremia, wound dehiscence, submaxillary gland infection, cerebral hemorrhage and hemiplegia, fecal fistula, mesenteric thrombosis, pyelitis, paralytic ileus, and subphrenic abscess. In addition to this, several patients had subsequent bowel resections during the same admission for the lesion causing the initial obstruction. Deaths following these procedures add to the mortality.

Eleven patients died of postoperative complications from the following causes: pneumonia, 3; pulmonary embolism, 2; pulmonary embolism and pneumonia, 1; pneumonia and lung abscess, 1; coronary occlusion, 1; cardiac decompensation, 1; mesenteric thrombosis following a subsequent resection, 1; and shock following a subsequent resection, 1. Thus we see pneumonia and pulmonary embolism were involved in 7 of the 11 deaths from complications.

Blood urea nitrogen is usually elevated in intestinal obstruction. Blood urea nitrogen determinations were done in 40 of these patients. Considering 20 to 40 mg. per cent as normal, we found that the blood urea nitrogen was elevated in 35 of the 40 cases. However, a high percentage of people in this age group have an elevated blood urea nitrogen associated with hypertension and latent nephrosclerosis. This makes it difficult to evaluate an elevated blood urea nitrogen in these patients.

Symptomatology, diagnosis, and relationship of duration of symptoms to mortality have all been adequately discussed elsewhere and need no further treatment here, except the mention of a few cases with bizarre symptomatology. In 1 patient the presenting symptoms were pain in the vagina for twenty-four hours, inability to void, and a tender, rigid lower abdomen. She had a herniation of strangulated ileum into the posterior cul-de-sac, for which 2 feet of ileum had to be resected. Another patient, 84 years old, had been nauseated and had vomited for twenty-four hours but insisted he had no pain. He died soon after admission to the hospital, and autopsy showed a volvulus of the jejunum causing strangulation. Two days after a vesical lithotomy in another patient nausea, vomiting, and abdominal distention developed, but no pain. Autopsy showed a mesenteric thrombosis. These cases serve to illustrate that pain may be absent or completely masked by other symptoms or be localized in areas where one does not usually think of intestinal obstruction.

For purposes of further analysis this series is broken down in table 3.

The individual groups will be discussed separately.

TABLE 3

Etiology of Obstruction	Number of Cases	Men	Women	Mortality	
				Number	%
Hernias	22	14	8	5	22
Carcinoma	9	7	2	4	44
Early adhesions*	9	7	2	8	89
Late adhesions	18	6	12	5	28
Miscellaneous	22	15	7	12	54

*Early adhesions refers to acute intestinal obstruction occurring during the hospital stay following operation.

TABLE 4.—*Hernias*

Type of Hernia	Men	Women	Total Number	Hernia Present For Many Years, No. of Patients	Number of Deaths
Inguinal	7	2	9	6	1
Femoral	5	5	10	5	1
Ventral	2		2	2	2
Vaginal		1	1	Had previous cystocele and rectocele repair	1
Total	14	8	22	14	5

These are cases of hernia in which complete obstruction of intestine was demonstrated at operation. Five of the 22 patients died, a mortality rate of 22 per cent. Of the deaths, 2 were due to pneumonia, 2 to pulmonary embolism, and 1 to shock.

In the 21 patients with inguinal, femoral, and ventral hernias, 13 had known of the presence of the hernia, most of them having known for several years.

Two of the cases were especially interesting. The patient in the first was a woman who complained of a mass and pain in the right lower quadrant, nausea, and vomiting for ten hours previous to entering the clinic. The patient was seen by several physicians, all of whom thought that the mass was intra-abdominal. Preoperative diagnosis was a torsion of an ovarian cyst. Operation revealed a right femoral hernia in which the bowel had dissected its way cephalad to the position where it was felt. The patient in the second interesting case was the woman with the vaginal hernia whose symptoms were described above.

Carcinoma

Nine patients, 7 men and 2 women, entered with symptoms of acute intestinal obstruction, which at operation were shown to be due to carcinomas, located as follows: rectosigmoid, 5 (one of these was recurrent following a previous resection); rectum, 1; ascending colon, 1; transverse colon, 1; and stomach extending to and obstructing the transverse colon, 1. Three of the patients had subsequent resections of the lesion. There were 4 hospital deaths, 3 from the obstruction and 1 from mesenteric thrombosis after a subsequent resection. These patients had had their symptoms the following number of days before admission: one day, 2; two days, 2; three days, 2; six days, 1; and seven days, 2.

Early Postoperative Adhesions

The most dangerous group of cases were those in which an obstruction developed following and on the same hospital admission as a previous operation. Of 9 patients in the group, 8 died. The one who survived had a gastric resection for carcinoma, and postoperatively there developed a wound dehiscence, a subphrenic abscess, and adhesions from the abscess, causing obstruction of the jejunum a month after the original operation. The previous surgical procedures involved in these cases were gastric resection for carcinoma, 3; acute obstructions from old adhesions in which adhesions were freed, 3; cholecystectomy, 1; first stage Mummery resection for carcinoma of the rectum, 1; and 1 in which there had been a resection of the sigmoid for acute diverticulitis, which had caused complete obstruction. There were 7 cases of obstruction of the small intestine, and 2 of the large intestine.

The patient in whom obstruction developed following cholecystectomy had been operated upon two years before for an acute intestinal obstruction caused by late adhesions.

In the 3 patients that entered with acute intestinal obstruction due to old adhesions and were operated upon and then became reobstructed, the question arises whether the reobstruction was due to new adhesions or to the adhesions that had caused the first obstruction. In 1 case reobstruction occurred five weeks after the first obstruction and at operation seemed to be due to a new adhesion distinct from the old adhesions. This patient also had a coincidental carcinoma of the stomach. In the second case a fecal fistula developed following the original obstruction which led to the adhesions causing the reobstruction three weeks after the first operation. In the third case reobstruction occurred three days after the first operation at the site of the previous obstruction.

Seven patients had enterostomies above the site of obstruction, and 2 had adhesions freed.

Late Adhesions

There were 18 patients, 6 men and 12 women, whose obstructions were due to late adhesions or bands. Five of the 18 died, 3 from obstruction, 1 from coronary occlusion, and 1 from pneumonia. Five of the 18 patients had had no previous surgical treatment. Of these, 1 had had hernia injections, 1 had adhesions from the internal inguinal ring, 1 had adhesions around the appendix, 1 had adhesions around the appendix and gallbladder, and 1 had an adhesive band to the pelvic brim apparently associated with a degenerating ovarian cyst.

One patient in this group had an interesting history. At the age of 73 she had a ruptured appendix, at the age of 83 an acute intestinal obstruction relieved surgically, at the age of 93 an obstruction relieved medically, and at 95 she died of old age.

The last group is made up of the following.

TABLE 5

Cause of Obstruction	Number of Cases	Number of Deaths
Mesenteric thrombosis	5	5
Retroperitoneal hemorrhage causing mesenteric thrombosis	1	1
Volvulus	3	2
Perforated appendix	3	0
Gallstones impacted in small intestine (1 jejunum and 1 ileum)	2	2
Acute diverticulitis	2	0
Lymphosarcoma	1	1
Carcinoids of ileum	1	0
Trauma	1	0
Inflamed appendix epiploicum	1	0
Tuberculosis of sigmoid	1	1
Undetermined etiology	1	0
Total	22	12

There are not enough cases in any of the categories of this last group to merit further discussion, except to mention the high mortality in mesenteric thrombosis.

Diagnosis and treatment of intestinal obstruction have received much emphasis and comment elsewhere. Early diagnosis and early treatment are especially important in this age group, as these people have a lowered resistance and do not tolerate well the dehydration, toxicity, and disturbances in electrolyte balance that accompany prolonged intestinal obstruction. The importance of early treatment is shown above in the analysis of the different types of obstruction. The best results were in obstructions due to strangulated hernia, probably because the presence of the obvious mass made the condition clear to the patient and his doctor, leading to earlier treatment.

Once the diagnosis of acute intestinal obstruction has been made, we believe surgical exploration should be done as soon as the patient is in the best possible condition. Dehydration and disturbances in electrolyte balance are corrected by intravenous fluids and electrolytes. Shock should be combatted by plasma and whole blood transfusions. Toxicity should be attacked with massive doses of penicillin. Streptomycin should be considered here also, although we have little experience as yet with its use in this condition. Vomiting and distention may be relieved by the use of suction. We would like to emphasize that the use of the Miller–Abbott tube or one of its many modifications is an adjunct in relieving distention but that its use, however, should not delay operation. Every series in which the Miller–Abbott tube is evaluated shows that it masks some cases of strangulation and in some cases does not decompress the bowel.[5] Where a simple obstruction due to an adhesive band may be relieved by simply freeing the adhesion, that same obstruction may in time become strangulated and require a much more extensive procedure, which is not well tolerated by elderly patients. As an adjunct to treatment, the Miller–Abbott tube may be of great assistance; as a substitute for surgical treatment, it is dangerous.

Postoperatively, fluid and electrolyte balance is important. Intravenous amino acids and massive vitamin therapy have their place in treatment.

Early ambulation in these elderly patients is important for early recovery and avoidance of complications.

Operation in most of our cases was performed under spinal anesthesia. This appears to be a somewhat controversial issue. Several authors attribute the use of spinal as one factor in the general decline in the mortality of intestinal obstruction. Others believe it is contraindicated, as many of these patients are in shock. Montgomery,[10] in his discussion of mechanical ileus in elderly patients, expressed the opinion that spinal anesthesia "should be only employed when administered by an anesthetist who is experienced in its use and who knows how to recognize the danger signals and how to meet the emergency."

Fifty-three of the patients in our series were operated on under spinal anesthesia. Of the 53, 20 died, giving a little less than 40 per cent, or close to the mortality rate of the series as a whole. Six of the 20 died in less than forty-eight hours postoperatively; data on these are as follows:

TABLE 6

Anesthetic	Blood Pressure			Operation	Condition of Patient and Cause of Death
	Preoperative	Lowest during Surgery	Postoperative		
Pontocaine, 20 mg.	134/90	90/70	126/80	Adhesions freed	This was the second operation on the patient for obstruction; adhesions were too massive to be freed
Pontocaine, 15 mg.	114/80	112/80	112/80	Adhesions freed Ileostomy	Died two days later from toxemia
Novocaine	80/60	60/40	60/40	Adhesions freed	Died two days later from toxemia and shock
Novocaine, 200 mg.	90/50	70/0	100/50	Gallstone removed from ileum	Died twenty hours postoperatively; he had been ill six days; it was thought to be cholecystitis until day of operation
Pontocaine, 20 mg.	100/60	84/60	84/60	Volvulus and adhesions freed	Blood pressure dropped to 84/60 two hours after spinal was given and was probably not due to spinal
Pontocaine, 20 mg.	130/70	100/70	128/40	Cecostomy	Died a few hours later with pulmonary edema and congestive heart failure

Table 6 shows that of these 6 patients 4 had a blood pressure at the end of surgical treatment that approached preoperative levels. In 1 patient operative shock apparently developed. One patient had a blood pressure of 60/40 apparently following the administration of the anesthetic. However, this patient had been ill for four days before admission and was toxic, dehydrated, and in shock, which makes evaluation of the specific cause of death difficult.

The primary danger to be feared from spinal anesthesia is a profound drop in blood pressure. Of these 53 patients, 15 had a significant drop, 10 of these going below 90/60. Analysis of these cases, however, shows no correlation between the blood pressure drop and the final result.

We believe that in experienced hands the blood pressure during spinal anesthesia can be adequately controlled. We use ephedrine or Oenethyl prophylactically in all cases. Intravenous fluids are given during surgical procedures, the rate of flow being adjusted to help maintain blood volume and circulatory efficiency. Five per cent dextrose in saline is used routinely, and blood and plasma when indicated. These measures, plus oxygen and the use of vasopressors, give good results. Recently we have been impressed with the use of a new vasopressor, Oenethyl.

Comment

Although this series is too small to draw any dogmatic conclusions, some inferences may be made.

1. Absence of abdominal scars does not eliminate the possibility of obstruction due to adhesive bands, as 5 out of 18 patients with obstruction due to adhesions had had no previous abdominal operations.

2. Persons in this age group probably do not well tolerate closely consecutive operations as evidenced by the 8 deaths in 9 cases of obstruction due to early postoperative adhesions.

3. Elderly people tolerate strangulated hernia fairly well; in 22 cases, only 1 patient died from the direct effects of the strangulation, although 4 others died of complications. This is probably explained by the almost universal presence of the hernial mass which leads to quick diagnosis and institution of treatment before the patient becomes too toxic.

4. Bizarre symptoms or signs may be present to confuse or mask the diagnosis.

5. Of the 34 deaths, 23, or about two-thirds, were due to the obstruction, and 11, or one-third, to postoperative complications.

Some future improvement in mortality could well be expected due to the development of antibiotics and chemotherapy; early ambulation; newer methods of controlling thrombophlebitis and pulmonary embolism; increasing the understanding of nutrition, vitamins, and amino acids; and better understanding of the associated diseases afflicting the aged. However, a significant feature here is that all of these primarily will affect mortality due to complications, which cause only one-third of the deaths. Blain's[11] work with penicillin, with which he has cut down the toxicity of obstruction, is an exception to this. It would appear that while we have new weapons to attack or prevent complications, the treatment of obstruction itself will remain unsatisfactory in the foreseeable future.

Summary

1. In spite of lowering mortality rates in acute intestinal obstruction generally, the mortality rate in old people is still excessive.

2. A study of 76 patients over 60 years of age with eighty acute complete intestinal obstructions is presented.

3. Thirty-four of the 76 patients died, a mortality rate of 44.7 per cent. Two-thirds died from the obstruction, and one-third from complications, a mortality rate of 32 per cent due to the obstruction itself.

4. The series is broken down and analyzed in five groups: hernias, carcinoma, early postoperative adhesions, late adhesions, and a miscellaneous group.

5. Spinal anesthesia is discussed.

6. Treatment is discussed.

7. A few inferences are made and discussion given of the present status of the problem.

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Bronchopulmonary Segments and Variations in Pulmonary Vascular Patterns*

By ARTHUR B. APPLETON, M. D.
London, England

THE recent developments of lung surgery have renewed interest to the details of lung anatomy. Fourteen years ago, Glass drew attention to subdivisions of the lungs which he called "bronchopulmonary" segments; they are much larger than the generally recognized "pulmonary" units but smaller than lobes. A segment has an apex directed towards the hilum of the lung and is ventilated by a single large bronchus. Each segment can be further subdivided into subsegments, each of which is ventilated by a subdivision of the bronchus. Segments and subsegments can be split apart and removed individually. A knowledge of the vascular arrangements of the individual segments is of importance for these surgical procedures. The arteries, both pulmonary and bronchial, are closely bound up with the branches of the bronchial tree; the tributaries of the pulmonary veins, on the other hand, are situated on the periphery of segments and subsegments. The larger veins of the intersegmental and subsegmental planes thus receive blood from both adjacent segments (or subsegments). Since fissures differ from intersegmental planes only in the presence of a pleural intrusion, large veins are commonly found on interlobar surfaces; they are also found on the mediastinal, though not commonly on the diaphragmatic or costal surfaces.

Unusual Developmental Arrangements

While each segment is commonly supplied by one large artery of the pulmonary system, it often happens that some part of the segment is not supplied by it but receives a branch from the artery of some other segment; such branches generally cross an intersegmental septum near the hilum.

In rare instances, some part of a lung may receive blood from the systemic arterial system or its blood may be drained into the systemic venous system. Such arrangements may be attributed to an unusual developmental derivation from a consistently present capillary network (over the lung-bud of the early embryo) which is in connection with both pulmonary and systemic circulations.

Fissures or clefts are liable to develop in any of the intersegmental planes; and the "normal" ones may be absent or incomplete.

Glass prepared maps showing the situations of the various segments, but found that no more than 85 per cent of lungs could be fitted into his description. Other authors have given descriptions differing in important details, while the relation of the segments to the openings of bronchi, visible on bronchoscopic examination, has been found to vary considerably. The relative sizes of segments have been shown to varay considerably with consequent differences in the situation of intersegmental planes.

Reasons For Variations

Embryologic study has satisfied me that the differences described are partly the outcome of differential growth in the various parts of the bronchial tree, but that there are also major variations which are due to initial differences in the pattern of budding of the bronchial tree in the embryo. These differences become stabilized at an early stage of development by the formation of blocks of cartilage in the 'keels' at the junctions of branches of the bronchial tree. I find that well-known bronchi and their corresponding segments are frequently missing and that adjacent ones occupy their customary territory. Thus either the apical, pectoral, or posterior bronchus of the right upper lobe is sometimes wanting, especially the apical; and that the apical is likewise often wanting in the left lung. Attempts by authors to fit all patterns of bronchi and segments into one single standard pattern are responsible for the difficulties and apparent anomalies they encounter. The number of major bronchi is not fixed: there may be fewer and there may be more than the usually recognized number.

Radiographic and bronchoscopic variations require consideration of the above-mentioned general principles for their elucidation.

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* Presented at the University of Wisconsin Medical School, Madison, on October 13, 1948.

Notes on Clinical Pathology

Editors—WALTER H. JAESCHKE, M. D., University of Wisconsin, Madison, and S. B. PESSIN, M. D., Marquette University, Milwaukee

Prevention of Syringe-Induced Infectious Hepatitis

The recently accumulated knowledge concerning the etiology, pathology, and diagnosis of infectious hepatitis has compelled physicians to consider methods for prevention of this disease. It has become apparent that in daily practice doctors, laboratory workers, and nurses may unknowingly be a vector in its transmission. Clinical and experimental evidence has divided "catarrhal jaundice" into two closely related groups, namely, "epidemic hepatitis" and "homologous serum hepatitis." Although as yet not isolated, it has been demonstrated that an unusually resistant virus is the causative agent. Infectious hepatitis may exist not only in its obvious, easily recognizable clinical form, but also without jaundice. The virus may remain in the blood stream for many months. There is thus established a large reservoir of carriers harboring the virus.

Patient-to-patient transfer of the virus causing "serum hepatitis" is accomplished either by administration of blood derivative or by transmission of the virus in the syringe. Serum hepatitis of this type has a higher mortality than epidemic hepatitis. Blood, plasma, and convalescent serum transfusions are sources for serum hepatitis. It is the responsibility of the blood bank to eliminate infectious donors. Nevertheless, because of the difficulty of recognizing carriers, occasionally a serum containing the icterogenic virus is inoculated into patients. In using blood derivatives, the risk of hepatitis must in each instance be weighed against the therapeutic effect.

One type of serum hepatitis is being recognized as "syringe hepatitis" in which minute amounts of virus may be transmitted from one patient to another by improperly cleansed syringes and needles. Three sources of contamination are to be considered. First, the syringe or needle may be improperly sterilized. Second, the syringe may be used for drawing blood from more than one patient without resterilization. The usual saline rinse between venipunctures does not necessarily remove the virus. When drawing blood, a back-flow into the vein results from the negative pressure in the blood stream. Consequently, if the virus is present in the syringe, it may be introduced into the vein of the second and all subsequent patients. Similarly, in intramuscular injections back pressure may force tissue juice harboring the virus into the syringe. Third, the stock medication or vaccine may become contaminated by expulsion of air from an infectious syringe into the vaccine bottle in the process of filling the syringe.

Special consideration must be given to the diabetic clinic, venereal disease clinic, tuberculous wards, cardiac service, and arthritic clinic for sources of infection. In the diabetic clinic multiple venipunctures for blood sugar determinations offer a possibility for contamination. Use of a common syringe for multiple insulin injections and contaminated insulin vials are also obvious sources of infection. In the venereal disease clinic, venipunctures for blood tests and the use of one syringe for multiple injections of arsenicals or bismuth are to be considered. In tuberculous patients frequent sedimentation rate determinations and streptomycin injections are possible sources. In arthritic clinics sedimentation rate determinations and gold injections, and in the cardiac clinic, dicoumarol injections, sedimentation rates, circulation times, and prothrombin determinations offer opportunity for syringe contamination. Mass immunizations in which a single syringe or a common vaccine vial is used are potential sources of infection. Penicillin injections or, in the operating room, intravenous anesthetics from a common syringe or vial are also hazardous.

In prevention of "syringe hepatitis" it is thus essential that certain safeguards be practiced. Adequate cleansing and sterilization of syringes and needles are most important. The equipment must first be cleansed of blood products. The practice of washing a syringe immediately after blood withdrawal or serum injections is recommended. Autoclaving or dry heat sterilization is the most certain method of killing viruses and bacteria. Boiling of needles and syringes is not generally as reliable, although twenty to thirty minutes of boiling is usually considered adequate. Chemical sterilization is ordinarily not recommended. The use of multiple venipunctures and medications from a single syringe should be discarded. As far as possible, stock bottle vaccines and insulin should be avoided. It would be preferable to permit each diabetic patient to have his own syringe, needle and insulin bottle. In general, all syringes and needles should be properly sterilized for each individual patient. Finally, blood, feces, and urine specimens from patients with hepatitis should be handled as potentially infectious, to prevent infection of laboratory personnel.—JOSEPH M. LUBITZ, M. D., Wood, Wisconsin

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As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Fluorination of Public Water Supplies Proves Its Value

Clinical research has repeatedly demonstrated to the health professions that where public water supplies naturally contain one part per million of fluorine, dental caries were reduced about 65 per cent. Many surveys were made by the Wisconsin State Board of Health demonstrating this phenomenon.

The question then arose as to whether or not we could artificially add fluorides to our public water supplies and produce the same beneficial results that were found where the fluorine is naturally present in the water. Authorities in chemistry and biochemistry were unanimous in the opinion that artificially fluorinated water was exactly the same as so-called natural fluorine water. Laboratory research and animal experiments showed that exactly the same results were produced with artificially fluorinated water as were produced with natural fluorine water. The fluorine found in water, whether it was natural or artificially fluorinated, was found to be in the ion form.

After considerable study of all the available data the Wisconsin State Dental Society in 1945 officially went on record as follows:

> "Resolution adopted unanimously by the house of delegates of the Wisconsin State Dental Society at the Seventy-fifth annual convention at Milwaukee on March 19, 1945.
>
> "WHEREAS:
>
> We the members of the Wisconsin State Dental Society's Fluorine Committee, convinced that the overwhelming weight of the evidence now precludes any doubt that a drinking water supply containing a concentration of one part per million of fluorine, as fluorides, inhibits dental decay,
>
> "AND WHEREAS:
>
> All evidence shows that the optimum of one part per million of fluorine, as fluorides, in water has produced no untoward results,
>
> "We therefore recommend that public water supplies deficient in fluorides have their concentration raised to one part per million of fluorine, as fluorides, to inhibit dental decay, providing that such addition is under dental, medical, engineering, and public health control."

The Wisconsin State Board of Health, after considerable study, paralleled the action of the Wisconsin State Dental Society and the present official policy of the State Board of Health is as follows:

> *"Fluorination policy adopted by the State Board of Health at its meeting on December 20, 1946:*
>
> "In the light of additional data and information now available relative to the addition of fluorine to public drinking water supplies as a means of reducing the incidence of caries in teeth in children, the Board hereby restates its policy re fluorination of city water supplies as follows:
>
> "Controlled fluorination of drinking water appears to give promise of a substantial reduction in tooth decay to children whose mothers were ingesting protective amounts of fluorine during pregnancy and who, as infants and children, have continued to use water containing 1 to 1½ parts per million of fluorine during their twelve years of life, and therefore the Board is in accord with having cities set up fluorination projects where acceptable controls are established and maintained."

As a result of this leadership in public health, three Wisconsin cities—Sheboygan, Elkhorn, and Madison—have been fluorinating their public water supplies for some time. Janesville, Fond du Lac, and Johnson Creek are installing equipment to fluorinate their public water supplies. Milwaukee, Beloit, Ashland, La Crosse, West Bend, Racine, Baraboo, and Fort Atkinson have introduced ordinances in their common councils for official approval to fluorinate their public water supplies.

In order to obtain the greatest benefits from the fluorination of public water supplies, an individual must drink this fluorinated water from birth till about 12 years of age. Surveys show that this immunity is retained throughout life. Hence, a city that begins to fluorinate its public water supply now will have to wait about twelve years before a 65 per cent reduction in dental caries can be demonstrated in their children. This is a long period to have to wait to show the public how much dental caries can be prevented by fluorination. There was no way of knowing how long we would have to wait following the fluorination of a public water supply before we could demonstrate an appreciable improvement in the dental health of the children. Therefore, it was decided to do a survey of all the school children (born and raised) in the city of Sheboygan before it began to fluorinate its public water supply (one part per million) in February 1946, and to repeat this survey annually following fluorination. In this way we could establish the decay rates on about 2,500 children before fluorination and each year following fluorination. Doctor Hildebrand, city health officer, has arranged for these surveys an-

(Continued on page 1246)

Recommendation on 1949 Dues by Reference Committee on Resolutions of the House of Delegates, October 1948

IT IS the duty of this Committee to recommend the dues that shall be applied in 1949. Consequently, the Committee has reviewed the activities and needs of the Society in considerable detail. It believes that the House should keep the following matters clearly in mind, and should further willingly accept the responsibility of developing them within their local county societies:

1. It is a matter within the knowledge of all of us that the country has been confronted with an inflationary trend in recent years, and there is no indication that it will not continue in the next year or possibly several years. The purchasing power of the dollar is considerably less than it was four years ago, yet the Society has operated with the same dues during this time, not without tremendous effort and the use of some reserve funds. During this same period the activities have been expanded and made even more valuable to the membership as a whole.

2. The Council of the Society most wisely, it seems to this Committee, has purchased a home for the Society's activities, sufficiently large to house all agencies and to provide quarters for committee and council meeting purposes. The total cost of this project will be in the neighborhood of $60,000—a cost which the Society has met by appropriation from the reserve account, necessitating liquidation of its investments and almost complete depletion of its cash reserves. With this move, however, much greater efficiency may be anticipated, with resulting values to the profession.

3. The Society is not merely a professional association with only occasional activities. Its own directed and operated prepaid medical-surgical plan is grossing more than $60,000 monthly in premium income, and there is every reason to expect its steady growth and expansion. The Veterans Medical Service Agency is receiving monthly authorizations totaling more than $30,000 and has served well in expediting the hometown medical care program of the veteran.

The radio program is conducted over twenty-five stations weekly, and produces a tremendous amount of correspondence from interested listeners. Committee activity is voluminous in many fields and has been productive of immeasurable results in the public health field. An indication of this lies in the work of the Technical Committee organized by the Society in an advisory capacity to the Legislative Council on studies of the State Board of Health. A 65-page report detailing its work and recommendations was filed with the Council. Similar studies are developed periodically in a wide range of fields. All of this has caused increased demands not only upon the staff but upon many committees and officers.

4. Your Secretary, the Assistant Secretary, and other members of the staff are in constant touch with national developments of particular concern to this State and, under direction of the Council and other official bodies, are available to county societies and other groups where their services may be helpful.

5. The Society actively and effectively serves many professional and scientific needs of the Society. The developing and conduct of this annual meeting and the scientific program is one example. Another is that of the presentation of twelve or more postgraduate clinics with State-wide availability. The periodic distribution of panels under the Compensation Act is another example. Public instruction through the press, and with its cooperation, is most outstanding. Much more could be outlined to you.

All this costs money. During this period of inflation it costs much more than formerly. The Society has no substantial cash reserve which, as a practical matter, should constitute at least one year's normal income.

In light of all these and other considerations, your Reference Committee recommends that the dues for the ensuing year be established at the total sum of $50 per each full dues-paying member, perhaps totaling 2,700 in all. Your Committee further recommends that $5 of this sum be earmarked for Society reserves, and that this action, if taken by the House, be conveyed to each member of the House, and each county president and secretary, through distribution to them of this section of your Reference Committee's report. If deemed appropriate, it is suggested that this might also be incorporated in the annual dues statement sent each member in 1949.

. . . . THE PRESIDENT'S PAGE . . . .

Propogator Non Carborundum Est

THE customary demeanor of the doctors at the St. Louis convention was definitely more serious and constrained than that which one usually sees at conventions of this sort. The attitude was definitely quite serious but constituted only in some instances an attitude of hopelessness. The reactions as to what must be done varied widely, from some who would paraphrase Churchill, saying, "We will fight them on the beaches, in the streets," etc.; to others who said, "What's the use—socialized medicine is coming anyway, regardless of what we do."

It has become obvious that, whatever effort we as an organization such as the American Medical Association, make for the public good as we see it, that effort will be interpreted by some in the light of selfishness and hindrance to progress on the part of physicians. Witness the Fairchild incident. An effort was made to save that community from the embarrassment of having a physician in residence in the community when it was not at all certain that he could become licensed. It is perfectly obvious that any qualifying or licensing law must, because of peculiar circumstances, work hardship on some individuals. The newspapers have made no mention of the untold benefit to the people of the state of Wisconsin in preservation of health, preservation of medical standards, and freedom from quackery that has accrued to them as a result of the standards set up by the health laws of the state of Wisconsin and State Board of Medical Examiners.

The purposes of the American Medical Association assessment of $25.00 was most clearly stated. Its fundamental purpose was to state medicine's case to the public in clear and concise terms. It was not solely or principally to maintain a lobby in Washington, but some newspapers, of course, and Mr. Ewing immediately construed and labeled this as a lobbying fund. We, as physicians, and the American Medical Association need feel no reluctance at being characterized as influencing legislation. American medicine has never failed to counsel with the sick. It need feel no hesitancy in advising on legislation affecting the sick.

The assessment is proper and deserving of support. The Board of Trustees of the American Medical Association was empowered to implement the Washington office and the Chicago office with adequate personnel to provide state medical societies and county medical societies with adequate information for dissemination to the public, stating medicine's case. We hope the Board of Trustees will act promptly.

There never has been a time in the history of American medicine when we as physicians must definitely make it a part of our business to keep adequately informed on current events in medicine. There is no time for discouragement or resignation.

It is obvious that we are caught in the net of social reform, and the pattern of procedure seems to be following that already established in Europe and especially in England: parity payments to farmers, social security, unemployment insurance, old age insurance, and, now, socialized medicine. Witness the subsequent changes in England: government ownership of railroads, mines, government restrictions on manufactures. The same thing must not happen here. It behooves American medicine to enlist the interest and aid of big business whose stake in the progress of social change must be as great as ours.

Keep your chin up; we have just begun to fight!

Karl Dauge.

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Introducing the Guest Editorialist

President of Associated Medical Care Plans since it first annual meeting in October 1946, Doctor Schriver has played a significant part in the development of prepaid health insurance programs in the United States. When organization of AMCP was approved by the House of Delegates of the American Medical Association early in that year, he was named to its Commission to develop preliminary organizational matters and approve application of prepayment plans for membership. He was well qualified for the position, being president of Ohio Medical Indemnity, Inc., a charter member of AMCP.

In addition to his work in medicine on a national level, the doctor has been active in medical affairs of his own state, having served as president of the Ohio State Medical Association. He is also a member of the 1948 House of Delegates of the American Medical Association. He maintains a private practice in Cincinnati and is professor of clinical surgery at the University of Cincinnati College of Medicine, his alma mater. During World War I, he served as an officer in the Army Medical Corps.

He presents this month's guest editorial, "What Now?"

What Now?

NO DOUBT the sweeping Democratic victory presents extremely serious threats to the preservation of the private practice of medicine. President Truman, on several occasions, without any equivocation has advocated federal compulsory sickness insurance. His right hand man, Mr. Oscar R. Ewing, in his report to the President, "The Nation's Health" a ten year program, supports the President's opinion. The President no doubt, and justifiably, will interpret his and the general Democratic victory as a mandate from the people to proceed with the enactment of laws to implement compulsory sickness insurance.

It seems to this writer that we have long since had the chips down and now are calling the hands. What, if anything, can the organized medical profession do to retain its freedom and dignity and continue to render the high quality of service without political domination and regimentation?

If we are to salvage any of our priceless heritage it is imperative that we establish a positive, intelligent leadership and cease our defensive negation of proposed change.

We must cease attempting to develop policies from the so called "grass roots," hoping to crystalize them at the national level. If we continue this technic we are doomed—for to be honest with ourselves the local profession has not exhibited either interest or knowledge of the socioeconomic problems which have been with us since 1932, when the report of The Hoover Cost of Medical Care Committee report was submitted. We have every right to expect from those whom we put in high position of our medical organization, development of national policies and establishment of programs to meet our problems. If they refuse to assume this obligation they demonstrate their unfitness for high position and leadership—and unity in the profession will never be achieved.

We of the medical profession individually enjoy the finest public relations of any group in the community; yet, paradoxic as it may seem, as an organization our public relations are, in my humble opinion, among the poorest of any organized group. Recently some effort has been made and study given to the problem of our national public relations. What progress will be made must be evaluated by future developments. However, as long as we fail to present our attitude and solution of the perplexing problems confronting the public, in positive action (not lip service) and leave to intermediary organizations the presentation of ideas of frustration and negation, we will never improve our public relations.

In scientific accomplishment, medical education, and health education of the public, we have rendered services for which the public should be sincerely grateful. We have succeeded in creating a demand for and great confidence in our abilities and in the value of our services; yet, we have made only feeble and un-united efforts to market these services. The public is not interested in how an attractive, serviceable commodity is made; they are interested only in how can it be procured.

In my opinion we can save the free and dignified practice of medicine by having direct relations with the public and discussion of common problems with the leaders of public thought in any and all groups. As vendors of medical services, we should accept the challenge that solving the problem of distribution and availability of our service is an obligation which must be shared with the public.

We have the vehicle to accomplish this end—the professionally sponsored voluntary, non profit, prepayment plans.

By cooperation we may preserve THE AMERICAN WAY; without it, we shall perish.

L. Howard Schriver, M. D

As It Looks From the Wisconsin Public Health Council

R. W. BARDWELL

As the first president of the Wisconsin Public Health Council, Richard W. Bardwell, director of the Madison Vocational and Adult Education School, is actively interested in the development of public information and opinion in support of the public health program. As a school administrator in Madison and La Crosse during the past twenty years, he has been successful in the development of favorable attitudes toward the schools.

The improvement of the health of the people of Wisconsin is an objective toward which many individuals and many groups within the state have been working for many years. During these years the program of the Wisconsin State Board of Health has been recognized as one of the best public health programs in the nation. In the completeness with which the program has been put into operation in every part of the state, however, there has been, in the opinion of the Board of Health itself, much to be desired and sought for. This incompleteness, or lack of thorough public health service throughout the state, has been due to a number of factors, chief of which has been the lack of an informed public opinion which appreciates the values of such a service.

It was to assist in the development and maintenance of such public opinion and support that the Wisconsin Public Health Council was formed in May 1948. Careful consideration was given to the plan for such a council. Suggestions were received from public health people in every section of the state. To the initial meeting on May 12, 1948, were invited twenty-five citizens at large, who were known to be sincerely interested in Wisconsin's public health standards, together with the representatives of twenty-five state-wide organizations that were interested in or related to public health work in the state.

It was believed that this was a group of Wisconsin people who would inform themselves in regard to the problems and their possible solutions in the field of public health, and extend this information through county organizations to all the people of the state. At their first meeting pertinent information regarding the public health program and public health needs in Wisconsin was presented. To develop an enlightened and participating citizenship was the real challenge presented to them.

At a meeting in July this group officially organized as the Wisconsin Public Health Council, the objectives of which are to promote and protect the public health of the peoples of Wisconsin. The members of the council believe that one of the best ways by which these objectives may be accomplished is through the development of interest and participation on the local level with the possible development of local health councils. Therefore the state council, under the direction and with the assistance of its secretary, who has received specialized training in this phase of public health, has been developing material, organizing public relations and speakers' bureaus, and helping in the planning and presenting of public health programs at the local level.

It is recognized by the state council that each community within the state is unique in some of its public health needs. Therefore no one single pattern of organization should be set up for all communities in the state. Each community is different in some ways from the others. So the method of local health council organizations must be adapted to the conditions which exist in each locality. The general purposes of the local health councils will, however, be the same throughout the state. These purposes may be stated as: (1) to obtain complete basic public health coverage within the local area; (2) to prevent overlapping and duplication; (3) to prevent overemphasis of one part of the program to the neglect of another; (4) to raise health standards; and (5) to promote cooperation and help the community to see the health program as a whole and act to improve it.

The representatives of the medical profession in the state have been instrumental in organizing the Wisconsin Public Health Council and in establishing its significant purposes. It is therefore hoped that the representatives of the county medical societies will take as active a part in the organization of the local health councils. The support of each county medical society is important. At the same time it should be recognized that the health council is not the project of any one group, but is truly a community endeavor. Its membership should include both voluntary and tax-supported health agencies as well as citizens at large.

When these health councils have been organized in the counties throughout the state, we believe that the 65 per cent of Wisconsin citizens who are now without the health protection of a full time local health department will receive that protection. When this is accomplished the resolution passed by the State Medical Society in October 1946 will be fulfilled. This resolution urged "the establishment at the earliest possible date of local, county, district or regional full time modern health service which is deemed not only in the public health interest but consistent with the Society's program."—R. W. BARDWELL, *President, Wisconsin Public Health Council.*

Income Tax Provisions Affecting the Medical Profession

I. FEDERAL

Introductory

THE subject of federal income taxes continues to be increasingly complicated and technical. It cannot be simplified beyond a certain point. A physician will find it economical, if only from the standpoint of time, to turn his income tax matters over to his attorney or accountant, so that he may concentrate in his own professional field.

No effort has been made in this article to consider the special problems which arise in medical partnerships of two or more physicians, or in connection with the operation of larger units of medical practitioners, including clinics. In the first place, units of that size ordinarily employ an attorney and a consulting accountant. Second, although their problems in the main follow those of individual physicians, and the text which follows is generally applicable to them, certain of their problems, such as the handling of shares of net income, donations and capital gains, are dependent upon individual agreements, and cannot be treated in a general article of this nature.

The advantages of preparing income tax returns correctly and of taking full advantage of all permissible deductions and exemptions are at least twofold. One is the saving of the physician's time. It is costly for him to have to submit needlessly to interrogation, either by interview or by letter. Second is the reduction in taxes, and the saving of possible later penalties and interest which come from the proper preparation of returns.

The physician must not forget that the present combined federal normal and surtax rate on net income (after deducting all exemptions, expenses, and other allowable items) begins at 16.6 per cent on the first $2,000 of such income and rises rapidly so that it amounts to 33.4 per cent on a surtax net income between $10,000 and $12,000; 49.3 per cent on surtax net income between $20,000 and $22,000; 57.2 per cent on surtax net income between $32,000 and $38,000.

1948 Revenue Act Changes

In April, 1948 Congress enacted the 1948 Revenue Act over President Truman's veto. It was welcomed by individual tax payers because it reduced rates and because it introduced the splitting of income between husband and wife where the spouses so desire. Generally speaking the splitting of income is an added means of reducing tax. Tax payers are thus afforded at least the advantage of lower rates under the new Act, and in many cases married persons will enjoy the second benefit of split income rate which will be discussed in fuller detail later.

Reduced Rates. The effective rates on the tax reduction may be summarized as follows:

(a) Persons with incomes of $2,000.00 or less after deductions and exemptions receive a 12.6 per cent reduction in their tax.

(b) Persons with incomes between $2,000.00 and about $136,700.00, after deductions and exemptions, receive a deduction of 12.6 per cent of the tax on the first $2,000.00 of such net income and a reduction of 7.4 per cent of the balance of their tax.

(c) Persons with incomes of $136,700.00 receive the reductions in the two steps stated in the preceding paragraph, plus a reduction of 5 per cent in the tax due on that portion of net income in excess of $136,700.00.

Split Family Income. The purpose of the split family income provisions of the 1948 Act is to equalize the tax burdens of married couples in community property and common law states. Under the statutes of about a dozen states it has hitherto been possible for a wife to return one-half the income, even though in point of fact she may have received none of it from her personal services or invested earnings. This was under the so-called "community" rule. This placed husband and wife at a corresponding disadvantage in the other three-fourths of the states which did not have such a rule. This disadvantage had increased significance as income tax rates were raised and became more steeply progressive.

Income splitting provision permits return of all income of the husband and wife on a joint return. It also permits a husband to join with his wife or a wife with her husband on a joint return even though one of the spouses had no personal income. The new rates are so devised that where such a joint return is filed by husband and wife it is, in effect, taxed as if one-half of such income belonged to each spouse. The tax reduction in such cases results from using the lower brackets of surtax returns twice, instead of computing one tax at progressively higher rates.

Thus beginning with the year 1949, physician tax payers in Wisconsin will, in common with all other citizens who make returns, enjoy the reduced rates, and where married will enjoy a further reduction in the overwhelming number of instances by having their wives join them in a joint return.

Who May File. The split income tax feature of the 1948 Act is limited to spouses who live together and have the same tax year. Divorced persons may not file such returns. Should one spouse die during the year who had the same tax year as the survivor, the survivor and the deceased spouse's estate may file a joint return and enjoy the advantages thereof just the same as though both had lived. The new law permits husband and wife to file a joint return even though one of them has no gross income or deductions.

When A Joint Return Is Advisable. It should be noted first that the filing of a joint return is optional just as it was in prior years. Formerly it was advantageous for married persons to file jointly only in the rare case where the tax on the combined income was lower than on the separate returns. This resulted usually from deductions and losses from one spouse which could not be fully offset against that

person's income. Under the 1948 law, the filing of a joint return usually reduces the total tax.

In almost all cases in which husband and wife have a combined net income over $2,000.00, after deductions and exemptions, it will be advantageous to file a joint return. One exception would be where both spouses have substantially the same net income. A second exception might arise where 5 per cent of the combined incomes would be insufficient to cover the medical expenses of both spouses, although maximum advantage might be enjoyed on separate returns. This situation will rarely exist, however.

Where each spouse has taxable sales or exchanges of property, it may not be advantageous to file a joint return dispite the income-splitting provisions. The only way to be sure whether a joint or separate return is more advantageous is to compute the tax both ways.

Mechanics Of Joint Return. No purpose would be served here by setting out the mechanics of the joint return under the 1948 Act. Suffice it to say that after determining net income the latter is divided in half, then one-half of the combined credits of the spouses is deducted from half of the net income, the tentative normal tax and surtax is computed on such amount, such computation is further reduced by the 1948 general reductions in rates and the resulting tax liability so determined is multiplied by two.

Obviously, if a physician has a net income for 1948 of $15,000.00 and can cut it in half for tax purposes, the resulting taxes on two $7,500.00 incomes is much less than the tax on a single $15,000.00 net income.

It should be remembered that the signatures of both spouses is required on joint returns. *Each* spouse is liable with the other and individually liable for part or all of the tax, as the government may elect. Thus, the government could collect the tax from the spouse who had enjoyed none of the income, so long as the latter had signed the return. Also, once a joint return is filed for a given year, neither party may seek to revoke the joint return by filing an individual return. The choice may be made each year, however.

Other Features of the 1948 Revenue Act

Standard Deduction. Under the 1948 Act, a husband and wife with a combined gross adjusted income of $5,000 00 or more may take a standard deduction on a joint return of 10 per cent of such combined income, or $1,000 whichever is less. If husband and wife make separate returns, the maximum standard deduction on each return is $500.00. An unmarried person may take a standard deduction of $1,000.00, or 10 per cent of adjusted gross income, whichever is less.

The standard deduction may be taken in place of the so-called "non-business" deductions. Ordinarily, such deductions would consist of such items as interest on the tax payer's residence, taxes on the home, state income taxes, losses from fire, storm, other casualty, or theft, (not compensated by insurance, lawsuit or otherwise) and medical and dental expenses. The latter are discussed more fully below.

Where husband and wife file separate returns, and one itemizes his deductions, so must the other. In other words, the standard deduction is *not* available to one spouse making a separate return unless the other also employs it.

Personal Exemptions. Personal exemptions and credits were raised from $500.00 to $600.00 each by the 1948 Act. It should be noted that in the case of dependents the credit allowed the tax payer is $600.00 but it may be taken only for dependents whose income is less than $500.00. No credit for a dependent may be taken where the latter has filed a joint return with a spouse. In such case a personal exemption can be taken, however. A special exemption of $600.00 for each tax payer over sixty-five is permitted, in addition to the ordinary personal exemption of such person. The Act also allows an *additional* exemption of $600.00 if the tax payer's spouse is over sixty-five, or attains such age during the year, provided such spouse has no gross income and is not the dependent of another tax payer.

The former special exemptions of $500.00 for the blind has been increased to $600.00. This is available to tax payer and his spouse. It should be noted that where a person is over sixty-five, or is blind, and is a dependent of a tax payer other than a spouse, no additional exemption is allowed such tax payer. As an example, a husband whose wife is over sixty-five, blind, and dependent upon him for support, may claim a triple exemption of $1,800.00 for such wife. If a son were supporting the wife instead of the husband, and the facts were otherwise the same, the son could claim only $600.00 exemption for his mother.

Medical Expenses. The 1948 Act did not change the earlier rule that only those medical expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. The new law did raise the ceiling amounts allowable, however. On a separate return no more than $2,500.00 may be deducted for medical expenses. On a joint return as much as $5,000.00 may be deducted. The maximum allowances will be summarized in the following table.

Joint Return	Maximum Allowable
Husband and wife	$2,500
Husband and wife and one other exemption	3,750
Husband and wife and two or more other exemptions	5,000

Separate Return	Maximum Allowable
One exemption	$1,250
Two or more exemptions	2,500

For further treatment of this subject see page 1202 of this article.

Alternative Tax. If there is an excess of combined net long-term capital gains over combined net short-term capital losses on a joint return the law provides an alternative method for computing the tax. Every dollar of such excess is taxed at a 50 per cent rate, and in some situations this may be lower than the tax regularly computed on form 1040.

Under the 1948 Act use of the alternative method will never result in a tax liability lower than that

regularly computed on form 1040 unless the combined surtax net income of husband and wife who make a joint return, after subtracting deductions and exemptions by adding the excess of capital gain, exceeds $44,000.00. The same statement would hold of an individual making a separate return on a surtax net income of $22,000.00 or over. These two figures are only turning points, and the computations must be made by competent people who will know whether the alternative tax increases or decreases the total tax liability.

For further consideration of this question see the subsection of this article beginning on page 1198 entitled "Capital Gains and Losses."

It will be obvious that the 1948 amendments summarized above represent substantial and immediate tax advantages to federal tax payers. The above summary does not pretend to be a full or adequate treatment of the subject. Further, it is by no means offered as a substitute for the preparation of returns by persons competent to do so.

Individual Income Tax Calendar

1949

15th of each month (except January, April, July and October). Pay income taxes withheld on wages to a government depository if more than $100 of such taxes was withheld during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return is filed on or before January 31, April 30, July 31, and October 31.

January 15. Pay final installment of estimated 1948 tax. Also final date for amending 1948 declaration of income or an individual tax return in lieu thereof. If a 1948 income tax return is filed by this date, it may incorporate any previous underestimate of 1948 income, and no penalty which would otherwise be imposed for underestimating such income will have to be paid if the full balance of the 1948 tax is forwarded with the return.

January 31. Due date of employer's return of tax withheld and Social Security tax for last quarter of 1948. Also deadline for withholding and Social Security tax payments. The employer must furnish to each employe whose wages exceed the amount of one withholding exemption during 1948, a written statement, Form W-2, showing the wages paid during 1948 and the amount of tax withheld on such wages.

February 15. Due date of information returns showing interest or rent payments of $600.00 or more and wage payments of that amount not subject to withholding.

March 15. The following are due on this date: (1) Due date of individual income tax return for 1948, for those whose tax year ends December 31, 1948, unless made on January 15. Any excess of tax shown on this return over tax withheld and amounts paid on tax during 1948 is due on this date. (2) Due date of Declaration of Estimated Tax for 1949; one quarter of estimated tax payable on this date. (3) File 1948 partnership and corporation income tax returns where the income tax year ends December 31, 1948. (4) File gift tax return, if any due, and pay any gift tax due.

April 30. Due date of employer's returns of tax withheld and Social Security tax for first quarter of 1949. Also deadline for withholding and Social Security tax payments to accompany returns.

June 15. Due date of second installment of estimated 1949 tax; date for filing Declaration of Estimated Tax where requirements were first met between March 1 and June 2. Amendments of Estimates previously made may be filed at this time.

July 31. Due date of employer's return of tax withheld and Social Security tax for second quarter of 1949. Also deadline for withholding and Social Security tax payments to accompany returns.

September 15. Due date of third installment of estimated 1949 tax; date for filing Declaration of Estimated Tax where requirements were not met until a date between June 1 and September 2. Amendments of Estimates previously made may be filed at this time.

October 31. Due date of employer's return of tax withheld and Social Security tax for the third quarter of 1949. Also deadline for withholding and Social Security tax payments to accompany returns.

1950

January 15. Pay final installment of estimated 1949 tax. Final date for amending 1949 declaration of income, unless taxpayer prefers to file his 1949 income tax return by that date.

Withholding Taxes and Declaration of Estimated Tax

Employers Required to Withhold. Every physician employing persons for wages which are subject to the withholding tax must withhold from such wage payments an amount computed in accordance with the formula or tables provided by the Commissioner of Internal Revenue upon request. The amounts so withheld must be paid by the tenth of the following month to a government depository (a designated bank) if a total of more than $100 of taxes was withheld from all employees during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return of taxes withheld is filed on January 31, April 30, July 31, and October 31.

Physicians should obtain from each employe an Exemption Certificate Form W-4 duly signed by the employe. This form should be obtained at the time employment begins. An amended form should be signed and filed with the employer whenever the latter's exemptions status changes. If no certificate is furnished the employer, no exemption is allowed in computing the amount of tax to be withheld.

Wages Subject to Withholding—Exceptions. Wages subject to withholding include all remuneration paid to an employe, whether designated as salary, wages, fees, commissions, et cetera, and whether paid in cash or in something other than cash.

Excluded from "wages" and not subject to withholding are the following:

(1) Fees paid to public officials, such as notaries public and sheriffs.

(2) Compensation for services as a member of the military or naval forces of the United States.

(3) Remuneration for agricultural labor.

(4) Payments for domestic service in a private home or college club or a local chapter of a college fraternity or sorority.

(5) Compensation for casual labor not in the course of employer's trade or business.

(6) Remuneration for services rendered as a minister.

Statement of Taxes Withheld. For 1947, and thereafter, the employer must furnish each employe in duplicate, with Form W-2, showing the amount of taxes withheld from his pay, even though no tax is deducted, if the wages paid to the employe exceed the amount of one withholding exemption as shown by the federal tables.

Filing Declaration of Estimated Taxes. Every physician must file a declaration of his estimated 1949 federal income taxes if:

(1) His gross income not subject to withholding tax is expected to exceed $100 and his gross income will be $600 or more.

(2) His gross income from wages subject to withholding can reasonably be expected to exceed $4,500 plus $600 for each exemption in addition to his own.

This estimate must be filed by March 15, 1949, and amended estimates may be filed on June 15, September 15, and January 15 following.

A husband and wife living together may file a single declaration on which they will be jointly liable.

Penalties. Penalties are provided for failure to file Declaration of Estimated Tax and failure to pay installments when required to do so.

For underestimating tax by more than 20 per cent (33⅓ per cent for farmers).—Six per cent of entire shortage in estimate, but not more than the amount by which the estimate falls short of 80 per cent of the tax (or, in the case of farmers, 66⅔ per cent of the tax). This penalty will not apply if (*a*) the estimated tax is computed on last year's income at this year's rates and exemptions, and is paid on time in equal quarterly installments, or (*b*) is paid ahead of time, or, (*c*) in the case of farmers, is paid in full on or before the 15th day of the last month of the taxable year, or (*d*) if an income tax return is filed and the full balance of the tax paid on or before January 15 of the succeeding year.

Summary of Applicable Provisions

Effort is made in this portion of the article to summarize for the assistance of physicians, or their office staffs, those provisions of the federal income tax law which most commonly apply to a medical practitioner and to operation of a medical office. No claim is made that the treatment is exhaustive. It is only a partial outline, but inasmuch as professional assistance would be required for more technical matters, it might prove confusing to go into any fuller detail than has been attempted here.

General Instructions. Income tax returns for all taxpayers reporting on a calendar year basis must be made to the Collector of Internal Revenue, Milwaukee, not later than March 15, 1949. An extension of time up to six months for filing a return can be had for reasonable cause. Application for extension should be filed with the Collector of Internal Revenue on form 1134, prior to March 15.

Responsibility for making all returns is in the individual. Liability to make a return depends not on whether one has a tax to pay but on the amount of his reportable income.

Dependants. Under the law as changed in 1944, the age of the dependent or his ability to support himself is no longer material. A dependent means one of the following persons over half of whose support for the calendar year in which the taxable year of the taxpayer begins was received from the taxpayer:

(a) A son or daughter of the taxpayer or a descendant of either.
(b) A stepson or stepdaughter of the taxpayer.
(c) A brother, sister, stepbrother or stepsister, half-brother or half-sister of the taxpayer.
(d) The father or mother of the taxpayer, or an ancestor of either.
(e) A stepfather or stepmother of the taxpayer.
(f) A son or daughter of a brother or sister of the taxpayer.
(g) A brother or sister of the father or mother of the taxpayer.
(h) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer.

"Brother" and "sister" include a brother or sister by the half blood. A legally adopted child is considered a child by blood.

The term "dependent" does not include any individual who is citizen or subject of a foreign country unless such individual is a resident of the United States, Canada, or Mexico.

No exemption for a dependent is allowed if the dependent's gross income was $500 or more, or if the dependent is married and has made a joint return with his or her spouse for the calendar year in which the taxable year of the taxpayer begins.

The fact that the dependent was not in existence throughout the year is immaterial. Thus, if a child of the taxpayer supported by the taxpayer is born or dies during the taxable year an exemption is allowable for such child.

In like manner, a taxpayer who is married during the year and claims an exemption for his wife is entitled to a full exemption for her for that year.

Compensation for Services of Children. Compensation for services rendered by a child shall be included in the gross income of the child and not in the gross income of the parent. This was a change made by the Individual Income Tax Act of 1944. Under the present law, the child is considered a separate taxpayer subject to the regular requirements as to filing and is entitled to a separate exemption for normal tax and surtax.

The parent or guardian of the child must file the required return where the child is unable to do so. Liability for the tax on compensation earned by the child is placed on the parent if not paid by the child.

Where the gross income of the child for the calendar year is $500 or more the parent is not allowed to consider the child a dependent.

Items Reportable as Income. Broadly speaking, income includes all wealth which comes into the taxpayer's hands, other than as a return of capital. It is not even necessary in all cases that the income be *actually* received before the close of the taxpayer's reporting year for him to be obligated to report receipt of a certain item as income. Thus, salaries or bonuses are sometimes set up in a given year, and are made available to the taxpayer, although not paid to him until after the first of the following year. He would nonetheless have to report such items ordinarily because of the availability of such income to him. This is known technically as "constructive receipt" of income. The same general rule would hold for dividend checks mailed before the close of the tax year, although not actually received by the taxpayer until a day or two after the first of the following year.

A general article such as this cannot give all the technical refinements which develop in determination of what is "income" under the internal revenue law. Generally speaking, however, the following items, which have some application to physicians as a group, are reportable as income:

1. Compensation for professional services, whether in the form of salary, personal earnings from the practice of medicine, or the share of profits from a professional partnership between two or more physicians. The salary paid by a branch of government must also be included as income; as must a teaching salary, lecturing fees, and the like. Physicians sometimes have income for personal services of a non-professional character such as executor fees for handling an estate, or capital stock received from a corporation as compensation. Such items are likewise reportable in gross income.

2. Earnings from investments. The most common of these would consist of cash dividends on corporate stock; interest from loans, bank savings, or bonds of business corporations; interest on U.S. savings bonds issued after March 1, 1941; rents from buildings and lands.

3. Income in the form of interest on life insurance proceeds held by the insurance company under an agreement to pay interest is includable in gross income. If a life insurance policy is surrendered by the insured for a lump sum in excess of total net premiums paid, the insured person realizes income to the extent of such excess over his cost.

As to annuities, or a matured endowment policy paid in installments under an option selected by the insured before the endowment matured, 3% of the cost of such annuity or endowment is includable annually in gross income, if that amount or more is received in payments in a particular year. The remainder of the income from either source for a particular year is excluded from gross income. When the aggregate amount excluded equals the cost of the annuity or endowment, the entire amount received thereafter must be included in gross income.

4. In addition to items strictly classified as "income," one is also obligated to report ordinary gains and losses on the sale of property owned by the taxpayer in addition to capital gains and losses. The latter subject is separately discussed on the following page. The subject of gains or losses, and when taxable or deductible as the case may be, is perhaps one of the most technical fields of federal tax law and should be placed in competent hands. Otherwise a tax may be paid needlessly in one instance, and penalties and interest needlessly incurred in another.

5. Income from royalties or from a farm or other business in which a physician is interested apart from his professional practice.

Items Not Reportable as Income. The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; damages received on account of personal injuries or sickness, whether paid by an insurance company or as a result of successful litigation; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income); corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned income received from sources without the United States by a citizen who is a bona fide nonresident for the entire taxable year except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in wartime.

Interest on obligations of a state or political subdivision thereof is excluded from taxation, but nevertheless must be reported in the proper schedule on the return.

Interest on the following obligations or deposits antedating March 1, 1941, is wholly exempt, but while excluded from taxation must nevertheless be reported on the proper schedules on the returns: Treasury bills and certificates of indebtedness, Treasury notes, except series D–1944 and B–1945, and deposits in Postal Savings banks, and obligations of the United States issued on or before September 1, 1917, obligations of United States possessions, obligations issued under the Federal Farm Loan Act, obligations of the Federal Deposit Insurance Corporation, and bonds of the Tennessee Valley Authority except those issued under the Act of July 26, 1939.

Interest on obligations of the Commodity Credit Corporation, Federal Farm Mortgage Corporation, Federal Home Loan Banks, Federal Savings and Loan Insurance Corporation, Home Owners Loan Corporation, National Mortgage Associations, Production Credit Corporation, Reconstruction Finance Corporation and mortgage debentures issued by the United States Maritime Commission where the obligation was issued prior to March 1, 1941, and dividends on share accounts in Federal savings and loan associations in case of shares issued prior to March 28, 1942, are exempt from normal tax but are subject to surtax.

Interest from Treasury bonds, including United States Savings bonds issued prior to March 1, 1941, is exempt from normal tax, but is subject to surtax except for exemption to the extent of the interest received on the first $5,000 of principal of such bonds. Example—Taxpayer holds $10,000 in principal of Treasury bonds, equally divided between issues bearing interest at 3 per cent and 4 per cent. He may claim exemption from surtax as to the interest received on the $5,000 of 4 per cent Treasury bonds.

Capital Gains and Losses. Capital gains and losses are now classified as follows:

(1) *Short-term* capital gains and losses are those resulting from the sale or exchange of capital assets held not more than six months.

(2) *Long-term* capital gains and losses are those resulting from the sale or exchange of capital assets held more than six months.

One hundred per cent of the gain or loss is recognized on short-term transactions, and 50 per cent on long-term transactions. After applying the proper percentages of gains and losses, both short-term and long-term are treated together.

It is important to note that a net capital loss is deductible against ordinary income only to the extent of $1,000. The portion of the net capital loss which is disallowed, because it exceeds $1,000 in a given year, may be carried over to the five succeeding years to be applied against any future capital gains and also against other ordinary income up to the $1,000 maximum in each such future year.

The alternative tax has been continued in so far as a net long-term capital gain, after reduction for any net short-term capital loss, is concerned. There is, however, no longer any alternative tax in the case of a long-term net capital loss. The rate has been increased from 30 per cent to 50 per cent, but since the rate applies to only 50 per cent of the actual gain, this represents an increase in the effective rate only from 15 to 25 per cent.

An important point for the physician who sold improved land during 1948 is that the 1942 act has repealed the artificial and unsatisfactory provision of the past under which land had to be separated from buildings and differently treated for income tax purposes at the time of sale. Land, under the former rule, was treated as a capital asset, but buildings and affixed equipment were not so treated because they were depreciable.

The entire gain or loss from a sale of improved business real estate is now treated as an ordinary gain or loss, with 100 per cent recognition for income tax purposes, except that the entire gain is treated as a capital gain, if the property was held more than six months. In such latter cases only 50 per cent of the gain is subject to tax.

If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness, are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

Individuals not involved in the sale or exchange of any capital or other assets during 1948 need have no concern over these capital gains or losses provisions.

Special Rule on Accounts Receivable

Certain types of taxpayers, including physicians, are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $15,000 on his accounts receivable records in a given year, but collects only $3,000 of it in cash during that year. He also collects in cash during that same year the further sum of $9,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $12,000, while his gross income on an *accrual* basis is $15,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is *actually received* in accounts, notes, interest, rent and similar items, because his losses from these

sources are so much higher than those of a commercial concern. Physicians recognize this fact from experience, and almost universally report on the cash basis.

Since 1934 there has been a provision in the revenue act which required that upon the death of a taxpayer a valuation should be placed on *all* accounts and other receivables which were uncollected at the time of such taxpayer's death, and that such valuation was to be *added* to the taxpayer's cash income in the year of death, although *none* of such accounts were in fact collected until subsequent to such death. The effect of this statute was to put on an accrual basis a person who died in the course of a tax year, and who had hitherto been on a cash reporting basis. It had the effect of subjecting to income taxation what was considered the fair valuation of all unpaid accounts due to the taxpayer at the time of his death.

Important Amendment of Accounts Receivable Rule. Without considering the legal basis for the above rule, it clearly worked an increasing hardship on physicians and other professional men, particularly as receivables have mounted during the past decade along with income tax rates. A 1942 amendment changed the above rule by providing that amounts which are accrued only by reason of the death of the taxpayer shall no longer be included in computing the taxable net income for the period in which falls the date of the taxpayer's death.

In other words, it is no longer necessary to accrue *for income tax purposes* and place a valuation upon the accounts and other receivables due as the date of death. One of the serious features of the former rule was that the estate of the physician or other taxpayer affected first had to pay an income tax on uncollected receivables and then had to pay an estate tax upon the same accounts (if the estate was otherwise subject to such latter tax), even though *no cash* was in fact received by the estate from the accounts within the time that the two taxes became due and were paid.

The 1942 amendment above summarized is extremely important to the practicing physician and may mean a saving of many thousands of dollars in taxes to his estate.

It should be emphasized that accounts and other receivables do not by any means escape taxation under the amendment, for such a result would be inequitable from the standpoint of the government. A valuation is still placed upon them, and if the estate is otherwise subject to a federal estate tax the accounts in that sense still pay one tax during the course of probate. The accounts themselves, however, are not treated as income excepting as they are collected. At the time of collection such income is taxed to the estate or to the beneficiary of the estate, depending upon the recipient.

The above amendment is a very favorable one to taxpayers particularly at this time. Like all other tax provisions, it is likely to be rather strictly construed by the tax authorities, and will not warrant any relaxation of sound business practices and the keeping of adequate accounting and other records. It is important for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not enter on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an account is bad and getting an allowance for it, thereby compelling payment of a tax on an account which neither you nor your heirs will ever collect.
2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against the reserve all accounts known to be in this classification.
3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

This rule is limited to the federal income tax, does not affect the state income tax due, and does not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

General Deductions

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

Optional Standard Deductions. Some physicians may find it to their personal advantage to use what is known as a "standard deduction." In the case of a physician whose adjusted gross income for federal tax purposes is *less than* $5,000, the standard deduction is 10% of such amount. In the case of the physician whose adjusted gross income (after taking out allowable business deductions) is $5,000 *or more*, the standard deduction is $500. This is in lieu of all personal expense items such as donations, interest on personal debts, state tax on gasoline and the like.

Index to Deductions

Automobiles, 1.
Depreciation.
Insurance, 1, 11(b).
Maintenance.
Repairs.
Salary of chauffeur.
Bad debts, 2.
Bandages, 4.
Depreciation.
Automobiles—25 per cent annually on cost price, 1.
Classification includes snowmobiles and other motive equipment.
Instruments, 4.
10 per cent annually on cost of surgical instruments and general equipment; 10 per cent on cost of x-ray equipment.
Medical library, 3.
10 per cent annually of cost price.
Office building, 5.
Office equipment, 5.
10 per cent annually of cost price (average).
Dues, 7.
Equipment, 4.
Both long and short-lived.
Fire losses, 11(d).
Professional equipment and other property.
Income, what is, p. 1197.
Income, what is not, p. 1197.
Installment sales, 11(9).
Insurance premiums.
Automobile, 1.
Malpractice, 11(b).
Professional equipment, 11(b).
Laboratory materials and expenses, 4, 11(c).
Legal expense, 11(a).
Library, 3.
Licenses, 8.
Medical expenses, 11(f).
Medical meetings, 9.
Medical supplies, 4.
Office expenses, 5.
Heat, light, supplies, telephones, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 6.
Professional dues, 7.
County Medical Society.
State Medical Society.
Special societies as:
American College of Surgeons.
American College of Radiology.
Any other paid in interest of profession.
Professional subscriptions, 7.
Salaries, 10.
Scientific meetings, 9.
Sales of spectacles, 11(e).
Taxes and licenses, 8.
Alcohol license.
Automobile license.
Gasoline and oil taxes.
Narcotic tax.
Occupational tax.
Property (real and personal)
Professional equipment and materials taxes.
Reregistration fees.
Social security taxes.
State income tax.
State unemployment compensation tax.
Theft of professional equipment, 11(d).
Traveling expenses, 9.
Both professional calls and scientific meetings.
Wages and salaries, 1, 10, 11(c).
Chauffeur, 1.
Clerk, 10.
Laboratory assistant, 10, 11(c).
Maid, 10.
Nurse, 10.
Stenographer, 10.
Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 10.

Explanation of Deductions

1. Automobiles. The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, chauffeur's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, *while on professional calls*, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be four years, 25 per cent depreciation based on cost price may be taken annually for four years. What has been said with respect to automobiles applies to other motive equipment.

2. Bad Debts. If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good, and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report.

3. Library. Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly annual depreciation equal to 10 per cent of the cost of such library may be deducted.

4. Medical Supplies and Instruments. Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical

supplies required for the operation of a physician's office may be deducted as necessary expenses, as may equipment, the life of which is less than one year. The average useful life of surgical instruments and equipment generally is now estimated at ten years which means that 10 per cent of the cost may be taken as annual depreciation. Roentgen ray equipment may be depreciated at 10 per cent of cost annually.

5. Office Expense. General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable *average* depreciation rate for office equipment, furnishings and fixtures. Specific items may be higher or lower than this rate. Thus, a typewriter which, it was estimated, would last only five years would warrant a 20 per cent annual rate; while metal filing cabinets, with an estimated useful life of not less than twenty-five years, would justify only a 4 per cent annual rate.

Where the space used for the conduct of a professional practice, including waiting rooms, examination rooms and laboratory, is owned by the taxpayer physician, or by a partnership of physicians, a reasonable depreciation may be taken annually on such building, based on its cost and life expectancy. If only a portion of a building is used for professional purposes, depreciation may be taken only on such portion.

6. Office Rent. If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house.

7. Professional Dues and Subscriptions. Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible.

8. Taxes and Licenses. Taxes paid upon materials required in professional work are deductible. All licenses which the physician is required to take out may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occuptional and reregistration taxes, state taxes on gasoline and motor oil for professional use of car, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under the Social Security Act. The social security tax deducted from the income of a salaried physician is not deductible by him, however, since it is considered an income tax.

The physician may also deduct all real estate and personal property taxes paid by him, even though the property taxed is not used for professional purposes. This would include, for example, taxes on a vacant lot or on a launch.

9. Traveling Expenses. Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending posgtraduate medical courses are *not* deductible, however.

10. Wages and Salaries. Deductions are permitted for the salary of a nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employees for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. Miscellaneous. (a) Legal Expenses.— Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessment or refund care, are deductible, but legal fee paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

(c) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) Losses by Fire, Theft, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable*, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction. Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft or otherwise, *where not compensated for by insurance or otherwise.*

(e) Sale of Spectacles—Oculists who furnish spectacles, etc., may enter as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

(f) Medical Expenses. Medical, dental, drug, nursing, hospital, and related expenses, including fees for services rendered by other physicians, *which are in excess of* 5 per cent of the taxpayer's adjusted gross income, may be deducted if *actually paid* during a given year. The cost of hospitalization, health and accident insurance may be included in such deduction, as may travel where directly related to hospitalization or recuperation, and the travel expenses of a minor child and parent, which are directly related to hospitalization and medical care. If any of the above expenses are compensated for by insurance or otherwise, they are not to be included in the total.

The maximum deduction for medical expenses on a separate return for one exemption is $1,250.00, and for two or more exemptions is $2,500.00. The maximum deduction in the case of a joint return by husband and wife is $2,500.00 where there are no other exemptions, as for dependents. This amount is increased to $3,750.00 where there is one dependent in addition to husband and wife, and to $5,000.00 where there are two or more dependents in addition to a husband and wife who make a joint return. Situations may arise where, by reason of the rule limiting medical expenses to the excess over 5% of adjusted gross incomes of husband and wife, a joint return will decrease the medical deduction in some cases. This will seldom occur, however.

The expense must be for the medical care of the taxpayer, his spouse, or a dependent. Taxpayers are required to furnish the name and address of each person to whom such expenses were paid, and the amount and approximate date of payment. Where a joint return is filed, the 5 per cent limitation is computed on the aggregate adjusted gross income of husband and wife. Payments for waiver of premiums on a life insurance policy are *not* includable as medical expense.

Example: Assume the taxpayer has an adjusted gross income of $10,000 and that the total of the medical, dental, hospitalization and related expenses paid in a given year for himself and his family was $1,500. Since there is no recognition given to such expenses up to the point where they equal 5 per cent of his adjusted gross income, the first $500 of his expenses are not deductible. He would, therefore, be allowed to deduct only the remainder, or $1,000.

(g) Installment Sales. Where a physician sells real estate, or where he makes a sale of personal property, such as his medical practice, or some other property which he is not in the business of selling regularly, and there is a profit on such sale, it is possible to spread that profit over a period of years, with consequent reduction in the income tax payable on such sale, assuming that he is otherwise in a favorable income position and so continues during the years when the balance of the payments are being made to him.

To gain such advantage it is required that the initial payment or payments following sale do not exceed 30% of the selling price. The remainder, of course, can be payable in whatever manner the parties agree in subsequent years. As a general proposition where the profit on such a sale is substantial, it would probably be advisable to spread payments over three to five years, especially where the physician may not need the money at one time, and is secured on the balance.

In the case of personal property such as accounts receivable or a piece of machinery, it is also a requirement that the selling price must exceed $1,000.00. In other words, taxable income is reported proportionately as the installment collections are made.

There are two possible disadvantages which may diminish or eliminate the intended advantages of installment sales. One is that reduced income or deductible losses during one or more of the years of collection of an installment sale might be sufficient to offset part or all of the profit of the sale. A second possibility is that future Revenue Acts might eliminate the tax advantages now permitted in reporting long-term capital gains. Nobody can foresee the future actions of Congress. It can only be said that to date those who have reported sales on an installment basis have in many cases derived a tax advantage from doing so. The matter should be carefully weighed by an attorney or a tax accountant.

II. STATE

1947 Legislation

The 1947 session of the Wisconsin legislature completely renumbered and reorganized chapter 71 of the statutes containing the income tax provisions. This reshuffling was done without effecting any substantive changes in the law, although a few such changes were made by other enactments.

Foremost of the substantive changes in the law was that enacted by chapter 23 of the Laws of 1947, creating an optional "short form" of income tax return available to persons with a gross income not exceeding $3,500. Married persons *whose combined gross receipts* do not exceed $3,500 *may* file a joint return on the optional basis. Since the limitation of gross income to $3,500 will exclude most members of the medical profession, and since most doctors must file the more detailed form 1, further details concerning the optional short form are not included herein.

Other changes enacted by the 1947 legislature are incorporated in the following text wherever applicable.

General Instructions

Returns of 1948 state income must be made to the assessor of incomes of the district in which the taxpayer resides, on or before March 15, 1949. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the assessor of the department of taxation for the district in which the taxpayer lives. Such extension must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Every resident, including minors from eighteen to twenty-one years of age, must file a return whether notified to do so or not.

Liability to Make Tax Return

If the status of the taxpayer changes during the taxable year, insofar as it affects personal exemption for husband and wife, head of family, or dependents, such personal exemption shall be apportioned in accordance with the number of months before and after such change, disregarding a fractional part of a month unless it amounts to more than a half month, in which case it shall be considered as a month.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. When a person changes his permanent residence to or from Wisconsin during the year, all income which follows residence may be reported on either of two bases. He must report all of such income received while a Wisconsin resident or that portion of such income for the entire year which the number of months' residence in the State bears to twelve, whichever is smaller. Personal exemptions are prorated on the basis of time of residence within and without the state.

Income Tax Return

The normal tax, which is graduated, varies from 1 per cent on the first $1,000 of net income to 7 per cent on net incomes in excess of $12,000. The teachers' retirement fund surtax is based on one sixth of normal taxes after deducting $37.50 from the net normal tax.

Income From United States Taxable

All wages, salaries or fees derived from personal services performed for the United States (see exception as to armed forces) or any agency or instrumentality thereof, are now taxable, effective January 1, 1939.

Capital Gains and Losses

The former provisions of the statutes relating to computation of capital gains and losses for surtax purposes have been repealed. Thus, full gains or full losses are now recognized irrespective of the time the asset was held, instead of being graduated, as formerly, on the basis of the time the asset was held.

Limits on Federal Tax Deduction

The deduction for *all* United States income taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income computable without the benefit of the deduction for such federal taxes, and *before* the deduction of contributions:

Example: The taxpayer's net income, for purposes of the Wisconsin return, before deduction of any United States taxes paid during 1948 and before deduction of contributions, is $5,000. He paid federal incomes taxes of $400 during 1948. Under the above limitation he could deduct only 3 per cent of $5,000, or $150 for federal taxes, although he had actually paid $400. This has the effect of subjecting a larger part of the taxpayer's net income to the Wisconsin law, even though the rates as such have not been increased.

Instructions on the Filing of Separate Income Tax Returns For Husband and Wife

The rules of the Department of Taxation provide:

1. If a wife has a separate income of her own and the husband and wife may not or do not elect to file a joint return on the optional tax from 1a, she must file a separate return on form 1W or optional tax form 1–Wa. In case she has no income, no return need be filed.

2. In the event that both husband and wife have income and file separate returns, the personal exemption of $17.50 for the head of a family may be divided between the two according to their own choice, that is to say, the husband may claim it all, or the wife may claim it all, or they may divide it between them as they see fit.

3. The earned income of children under eighteen years of age shall be included in the return of the husband, widow or head of a family, and the personal exemption for such children or dependents shall be allowed to the husband or may be divided between him and his wife as they may elect, or shall be allowed to the widow having such children. The exemption allowed to the head of a family, other than a widow or widower, supporting children under the age of eighteen shall be limited to a deduction of $17.50 from the tax.

Personal Credits and Exemptions

The statutes themselves are so clear as to personal exemptions, credits for dependents, and the date determining the personal status of a taxpayer for income tax purposes that they are quoted here in full.

"71.03 (2) **EXCLUSIONS.** There shall be exempt from taxation under this chapter the following:

(a) Pensions received from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance

company, fraternal benefit society or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employes."

* * *

"71.09 (6) There shall be deducted from the tax after the same shall have been computed according to the rates in section 71.09 (1), a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term 'head of a family' means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional four dollars.

(d) For each additional person, except persons defined in section 71.09 (6) (c) who is actually supported by and dependent upon the taxpayer for his support an additional $4, except in case of head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the income of the wife and the income of each child under 18 years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family, but if not paid by him may be enforced against any person whose income is included within the tax computation.

(e) If the status of the taxpayer, insofar as it affects the personal exemption for husband and wife, head of family and/or dependents, changes during the taxable year, the personal exemption shall be apportioned, under rules and regulations prescribed by the department of taxation, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month shall be disregarded unless it amounts to more than a half month, in which case it shall be considered as a month."

Deductions

A. Statute

The statute setting forth what constitutes allowable deductions of major items of expense is so clear that portions of it are reprinted here as an aid to physicians in making state returns:

"71.05 **Deductions from Incomes of Persons Other Than Corporations.** Persons other than corporations, in reporting incomes for purposes of taxation, shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deductions shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of $700 or more shall have been paid for services during the assessment year. Except as provided in subsection (9) of this section, no deduction shall be allowed under this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation or business from which the income is derived, including a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived, and in the case of mines and quarries an allowance for depletion of ores and other natural deposits on the basis of their actual original cost in cash or the equivalent of cash.

(3) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(4) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided, that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further, that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the state of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(4a) The deduction for all United States income, excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of the deduction of said United States income, excess or war profits and defense taxes, and before the deductions of amounts permitted by subsection (6) of this section. In no event shall any taxpayer be permitted hereunder a total deduction in excess of the actual amount of United States income, excess or war profits and defense taxes paid, and otherwise deductible.

(5) Dividends, except those provided in sections 71.03 (1) (e) and 71.03 (2) (d) received from any corporation conforming to all of the requirements of this subsection. Such corporation must have filed income tax returns as required by law and the income of such corporation must be subject to the income tax law of this state. The principal business of the corporation must be attributable to Wisconsin and for the purpose of this subsection any corporation shall be considered as having its principal business attributable to Wisconsin if fifty per cent or more of the entire net income or loss of such corporation after adjustment for tax purposes for the year preceding the payment of such dividends was used in computing the taxable income provided by chapter 71, * * *.

(6) Contributions or gifts made within the year to any national organization of veterans of the armed forces of the United States or subordinate unit thereof, or to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation or association operating within this state, organized and operated exclusively for religious, charitable, scientific or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of 10 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

(7) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

(8) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition. Reserves for contingent losses or liabilities shall not be deducted.

(9) Payment for expenses for hospital, nursing, medical, surgical, dental, and other healing services and for drugs and medical supplies incurred by the taxpayer on account of sickness or of personal injury to himself or his dependents in excess of $50 but not more than $500.

(10) Any and all sums not to exceed eight hundred dollars paid by any person whose total income shall be three thousand dollars or less by way of alimony to a former spouse and not to exceed four hundred dollars each for the support of minor children under any order or decree of any court.

B. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Insurance, 1, 4.
  Maintenance.
  Professional use.
  Repairs.
  Salary of chauffeur.
Bad debts, 2.
Bandages, 9.
Conventions, 8.
Contributions and gifts, 16 (f).
Depreciation.
  Automobiles—25 per cent annually of cost price, 1.
  Instruments, 9.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on roentgen ray equipment.
  Medical library, 6.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dividends received, 3.
Dues, 12.
Equipment.
  Office, 10.
  Professional, 9, 16(a).
Fire, loss by, 7.
Instruments, 9.
Insurance premiums, 4.
  Automobile, 1.
  Malpractice, 4.
  Professional equipment, 4.
Interest paid, 5.
Laboratory materials, 9, 16(a).
Legal expenses, 16(b), 16(d).
Library, 6.
Licenses, 13.
Losses, by fire, flood, theft, suit, etc., 7, 16(d).
Medical convention, 8.
Medical expense, 16(g).
Medical supplies, 9.
Miscellaneous, 16.
Office expenses, 10.
  Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.

Office rental, 11.
Postgraduate studies, 14.
Professional conventions, 8.
Professional dues, 12.
  County Society.
  State Society.
  Special societies as:
    American College of Surgeons.
    American College of Radiology.
  Any other paid in interest of profession.
Professional subscriptions, 6.
Salaries, 15.
Sale of spectacles, 16(c).
Scientific meetings, 14.
Subscriptions, 6.
Taxes and licenses, 13.
  Automobile licenses.
  Federal income—3 per cent maximum.
  Import duties, etc.
  Personal property taxes.
  Professional license fees.
  Real property taxes on office owned and used by taxpayer in practice.
  Social security taxes.
  Wisconsin income taxes and surtaxes paid.
  Wisconsin unemployment taxes.
Theft, loss by, 7.
Traveling expenses, 14.
  Both professional calls and scientific meetings.
Wages and salaries, 15.
  Chauffeur, 1.
  Clerk, 15.
  Laboratory assistant, and technicians 15, 16(a).
  Maid, 15.
  Nurse, 15.
  Stenographer, 15.
  Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 15.

C. Explanation of Deductions

In numerous instances below, references are made to numbered paragraphs of the federal portions of this tax summary. (See p. 1200). Explanation of of any capital or other assets during 1948 need have to repeat explanatory paragraphs applicable equally to the making of state and federal returns.

1. **Automobiles** (See paragraph 1, page 1200).

2. **Bad Debts** (See paragraph 2, page 1200).

3. **Dividends Received.** Cash or property dividends received from a corporation's surplus accumulated since January 1, 1911, are deductible by the persons receiving the dividends, if the following requirements are fulfilled:

(a) The corporation paying the dividend must have filed a Wisconsin income tax return for the year preceding the payment of the dividend.

(b) The income of the corporation paying the dividend must have been subject to the Wisconsin income tax law for the year preceding the payment of the dividend.

(c) The principal business of the corporation paying the dividend must have been attributable to Wisconsin for the year preceding the payment of the dividend.

If 50 per cent or more of the entire net income or loss of a corporation, after adjustment for income tax purposes, for the year preceding the payment of a dividend, was used in computing the taxable income of such corporation, it will be considered that the principal business of such corporation was attributable to Wisconsin.

Note: Stock dividends do not constitute taxable income until the stock is sold. Liquidating dividends do not constitute taxable income until the taxpayer has recovered his cost of the stock so held. Any amounts received in liquidation in excess of the taxpayer' cost constitute taxable income.

4. **Insurance Premiums.** Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used for strictly professional purposes.

5. **Interest Paid.** Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal incomes taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

6. **Library.** A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact

(Continued on page 1207)

The
MEDICAL FORUM

The Wisconsin Medical Journal — December, 1948

REQUEST MORE PERSONNEL FOR MENTAL HOSPITALS

PHYSICIANS TO BE ASSESSED $25 FOR FUND TO FIGHT NATIONAL MEDICINE

St. Louis, Dec. 2.—The House of Delegates of the American Medical Association voted unanimously to assess each member of the association $25.

The fund thus obtained from 140,000 member physicians will be used for a nationwide plan of education on the progress of American medicine, the importance of the conservation of health and the advantages of the American system in securing a wide distribution of a high quality of medical care.

The assessment will come to the members through the state and county societies.

The action was taken "to meet the proposal of the present administration and particularly of the present Federal Security Administrator to nationalize the services of the medical profession through the enactment of a compulsory sickness insurance act covering every person in the United States," an AMA editorial declared.

The AMA delegates restated their conviction that "voluntary medical care insurance can and will solve the economic problem."

"Coverage is now provided throughout the country and protection is being extended rapidly to an ever increasing proportion of our population.

"The great accomplishments of American medicine are the result of development by a free profession working under a free system unhampered by government control.

"The experience of all countries where government has seized control of medical care has been progressive deterioration of the standards of that care to the serious detriment of the sick and needy.

"Compulsory sickness insurance, notwithstanding misleading political propaganda, is a variety of state medicine and possesses the evils inherent in any politically controlled system."

AMA OK's National Enrollment Agency; Rejects Nation-Wide Insurance Company

St. Louis, Dec. 2. — A national enrollment agency for Blue Cross–Blue Shield plans was given the go-signal by the American Medical Association at its St. Louis interim session, but the delegates turned down a proposal for the formation of a national Blue Cross–Blue Shield insurance company.

The formation of a national enrollment company will enable Blue Cross and Blue Shield plans to enroll national accounts—large concerns and industries employing persons in many states.

No Details

No details have been released as yet concerning the method by which these accounts will be handled in each state.

The national insurance company was rejected as a "step on the road to socialized medicine" and a plan that would establish standard minimums throughout the nation and adversely affect the autonomy and flexibility of local plans.

Hawley Comments

Following the AMA decision, Dr. Paul R. Hawley, chief medical officer, Blue Cross–Blue Shield Commissions, declared that he would go ahead with plans for a "single package" prepaid program despite the AMA's opposition.

The American Hospital Association has also voiced its opinion in favor of a national insurance company.

Doctors Doing Best They Can; Need More Staff, Better Facilities

Madison, Dec. 9—Mendota and Winnebago state hospitals for the mentally ill are badly in need of more funds, personnel and facilities if they are to meet even minimum standards, the State Medical Society's committee on mental hygiene, institutional care, public welfare and state departments has reported to the state board of public welfare.

The committee reported that more desirable methods of care and housing of the mentally ill cannot be realized until the improvements which it recommends have been accomplished. Members of the committee are Drs. H. H. Christofferson, Colby, chairman; B. J. Hughes, Winnebago; O. H. Epley, New Richmond; P. R. Minahan, Green Bay, and W. A. Munn, Janesville.

State Responsibility

Expressing confidence that the citizens of the state will approve a realistic program requiring the expenditure of considerable amounts of tax funds, the committee said, "The state, through its legislature, has a direct responsibility in maintaining services at a much higher level than they now exist."

Increased Budget Needed

The committee recommends budgets for Mendota and Winnebago sufficient to provide a basic staff of 12 physicians at each hospital; improved salary schedules to obtain more personnel, construction of more and better facilities; special facilities and personnel at both for an affiliate nurses' program; enlarged social service programs; an educational program in psychiatry for interns and residents, and a diagnostic center at Madison.

(Continued on page 2)

British Health Plan Termed a "Tragedy"

Excessive Demands on Doctor's Time; Reduced Incentive

Chicago, Nov. 18.—The tragedy which has befallen the British medical profession under socialization offers a clear lesson on the danger of government medicine to the United States, Dr. Warren H. Cole, of Chicago said in an address here.

Dr. Cole, a leading surgeon and faculty member in the University of Illinois College of Medicine, recently returned from a three-month stay in England as a member of an American state department medical mission.

Dr. Cole said, "Any advantage that might be put forward to justify the operation of medical service by government is immediately neutralized by the fact that quality of medical care promptly nosedives.

"There are several reasons why this happens.

"First, the number of office visits increase tremendously. Doctors in England are already overwhelmed by present demands on their time, and they do not have time to examine all patients thoroughly. Incidently, the patient who makes the loudest complaint will be the most likely to receive attention. As a result many persons suffering from such diseases as diabetes, tuberculosis, and intestinal cancer are neglected until it is too late.

"Again, the doctor has no incentive to do good work. There is no financial reward and the stimulus of competition is eliminated. If one doctor conscientiously tries to maintain the quality of his work, patients immediately transfer themselves to his panel, so that he no longer has time for patient study.

"A third factor is that, when patients, thinking they are not paying for medical care, crowd the doctor's time with troubles they would otherwise disregard, the doctor becomes disgusted with practice and becomes lax in his vigilance for serious disease.

"Fourth, most doctors are unhappy and dissatified with socialized medicine, which results in deterioration in their efforts."

Dr. Cole also reported that the government's confiscation of hospitals in Britain has destroyed community interest in such institutions, while the increased demand for hospital beds by undeserving patients makes it difficult for really sick persons to be accepted as patients.

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Mental—

(Continued from page 1)

Doctors at both institutions are doing the best they can with existing facilities, the committee emphasized.

Both hospitals are greatly overcrowded. The committee recommended that each receive 14 more physicians; over 100 more nurses; at least 17 occupational therapists; at least 12 more physiotherapists; at least 16 recreational therapists, and 12 social workers. The supply of attendants is nearly adequate.

Pointing out that Mendota was built in 1860 and Winnebago in 1872, the committee said it would cost $10,000,000 to replace them, but that they could be remodeled for use by specific types of patients for about $3,000,000.

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Editorially Speaking

STATE HEALTH INSURANCE?

[The following editorial is reprinted, by permission, from the December 2, 1948 issue of the Neenah *News-Times*.]

A state health insurance bill is to be offered the 1949 state legislature through State Senator Melvin Laird, Jr., of Marshfield. He wants to effect payments of $21 a week for workers who lose time because of illness. He would have the employers and employes pay it jointly.

Health insurance is not a state, or other government, responsibility. Or is it? Are people getting so minded on leaning upon the government, that they want the state to take care of them when ill? The government is already in life insurance, to a degree, with social security and with some of the pensions.

And who is going to pay for the $21 weekly, Senator Laird?

Social security now costs the employer and the employe 1 per cent of the wages paid, with an increase in social security eminent. This is on a national scale, and social security does not pay as much as $21 a week, either. The social security is paid originally by the employe, who pays it again in higher consumer goods prices, for the employer passes on his portion of social security, in higher consumer goods prices. And for the intricate handling of social security, both employe and employer pay more in taxes. But social security funds are not being set aside at interest in good investments, but are being spent—and when the time comes when the government is paying social security to any proportion of the populace, the government will have to raise more money through taxes for social security money which has been spent before used for the purpose intended.

Health insurance and any other socialistic benefits will run this same gamut.

The more that the American relies on the Great White Father in Washington for his old age, his ill health, and the other natural phases in life, the less actual independence he will have.

Let those who will have health insurance, buy it from insurance companies.

Compulsory Health "Certain" to Be Studied by 81st Congress: Lawrence

Department of Health Will Be Considered on Jan. 13

Washington, D. C., Nov. 9.—The 81st Congress, which will convene on January 3, will have approximately twenty per cent new members in each House with the result that the organization of both is likely to be a troublesome problem, declares Dr. Joseph S. Lawrence, director of the Washington office of the A.M.A.

Not Wise to Forecast

"It would be neither wise nor safe to attempt to forecast what this Congress will do in the health field before we read what the President will recommend in his message to Congress," said Dr. Lawrence. "In the meantime, the medical profession should recognize the opportunity and responsibility to inform the members of Congress, and especially the new members, on the problems involved in changing our medical care program."

Unfinished Business

Dr. Lawrence pointed to several items of unfinished business which will probably be taken up by the 81st Congress.

1. The Hoover Commission, established to promote economy, efficiency and improved service in the executive branch, will report by January 13. It will undoubtedly recommend the elimination of some government health activities and consolidation of others. It will also comment on the creation of a department of health.

New Health Bill

2. The Senate subcommittee on health has continued its study of national health problems and relevant legislative proposals and will report by March 15.

3. A new health insurance bill is certain to be drafted along the lines adopted by Federal Security Administrator Ewing in his report to the president on the National Health Assembly.

School Health Act

4. A school health act authorizing states to set up programs for the medical examination of school children will be acted upon by the next Congress. The American Parent Committee, promoter of one of the bills, is holding two conferences this month to preview this legislation.

5. The Congress may consider the problem which has arisen as the result of the vast Veterans Administration hospital construction program. This program has developed so rapidly that the V. A. now has more beds available than it can staff with doctors and nurses and more than are needed for service-connected patients. In addition, many communities report that the V. A. hospital building program and the Hill–Burton Act are going ahead in the same area.

32 Preceptors at Scientific Meet

Madison, Nov. 20.—Thirty-two physicians associated with the staff of the extramural preceptors of the University of Wisconsin Medical School attended a two-day scientific meeting in Madison covering clinical and research progress in medicine.

The University of Wisconsin medical school is the only school in United States which carries out this type of teaching for its senior medical students. It means that senior students spend three additional months in training with practicing physicians in the field. This system has resulted in a number of graduates locating in rural areas of Wisconsin.

The preceptors who attended the University meeting are:

Drs. P. A. Midelfart and H. F. Derge, Eau Claire; W. T. Clark, R. W. Farnsworth, G. S. Metcalf, W. A. Munn, V. W. Koch, T. J. Snodgrass and S. A. Freitag, Janesville;

Drs. C. F. Midelfort, T. E. Gundersen, P. C. Gatterdam, J. C. Harman and M. A. McGarty, La Crosse; Woodruff Smith, Ladysmith; K. H. Doege, R. S. Baldwin, S. Epstein and J. B. Miale, Marshfield;

Drs. W. S. Bump and W. K. Simmons, Rhinelander; P. B. Mason, W. G. Huibregste, J. W. McRoberts and E. G. Schott, Sheboygan; R. H. Schmidt, Jr., and Helen Marshall, Wales; H. H. Christensen, J. F. Smith, W. C. Becker, G. H. Stevens and M. L. Jones, Wausau.

PRESSLY IS FAMILY DOCTOR OF 1949

St. Louis, Dec. 1.—A South Carolina physician who gave up a career in big league baseball in order to practice medicine has been named the outstanding family doctor of 1949. He is Dr. W. L. "Buck" Pressly of Due West, S. C.

Doctor Pressly has practiced in Due West for 32 years and has won the unofficial title of "Father of Public Health" in this area. He is known as an authority on rural health and sanitation in his state.

In his younger days, Doctor Pressly wanted to be a doctor but didn't have the money. To get it, he played baseball while attending medical school at Emory College in Atlanta. He turned down an offer from the Pittsburg Pirates and made up his mind to switch to doctoring in 1912.

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Doctors Assail Ewing's Compulsory Health Plan

Dr. C. O. Vingom

Ewing May Head New Health Department

Washington, D.C., Nov. 8.—The creation of a new Federal department on health at the Cabinet level will be recommended by the Hoover Commission, according to Gerald G. Gross, editor, Washington Report on the Medical Sciences.

Mr. Gross reports that Federal Security Administrator Ewing has already picked a name for the department—Department of Human Resources. He adds that Ewing will probably be the first head of the department which will consider the government's activities in medicine, public health, education and social welfare.

Charges Plot for World-Wide Government Control of Medicine

St. Louis, Dec. 1—A charge that groups of laymen are fostering worldwide government control of medical care was issued at the A. M. A. interim session by Dr. Louis H. Bauer, Hempstad, N. Y., a member of the A. M. A. board of trustees.

He said this government medical service would be compulsory. It would be achieved by the various nations of the world interchanging their social security benefits.

Doctor Bauer said that international control is favored by the International Social Security association and the International Labor organization. He said these groups want complete medical care throughout the world.

Expose Ewing Philosophy of Free Choice; Call Plan "Un-American"

Madison, Dec. 9.—Two state physicians, one in Milwaukee and the other in Madison, have branded Federal Security Administrator Oscar Ewing's plan for national health insurance as "thoroughly un-American" and "a headlong plunge into socialism."

In Madison, Dr. C. O. Vingom, a councilor, told members attending the Third Councilor District meeting that free choice of medical care is a fundamental freedom of all mentally competent citizens and that Ewing's plan was a "decidedly un-American" system.

Dr. Vingom cited his experience with the Federal Bureau of Employee's compensation, a Ewing administered agency, as an example of Ewing's philosophy of free choice. In reply to Vingom's letter asking how U.S. employees are covered in industrial injury cases, Ewing said that his Bureau "designated physicians for the treatment of injuries, and for other than emergency treatment it is required that the employees utilize one of these physicians if they expect the Government to pay the bill. Nine such physicians have been designated for Madison."

"This means that out of 300 local (Madison) physicians, only nine are available for free choice," Dr. Vingom pointed out.

Try to Confuse Public

In his inaugural address, Dr. L. J. Van Hecke, new president of the Medical Society of Milwaukee county, declared that the "Biemillers, the Ewings and other socialists" are "feeding the nation into somnolence with pap."

"How does it happen that the physician is forced to defend his very defense of health?" he asked. "What kind of perverted English has got this thing around to the point where health sounds like something we are against?"

Dr. Van Hecke charged that advocates of national health insurance "apparently intend to confuse the public into believing an untruth—that we are an unhealthy people." That is a patent, irresponsible lie, and the people who dish out this nonsense know it."

Dr. L. J. Van Hecke

Call Federal Health a "Political Maneuver"

Friedman Says Ewing "Promises Miracles He Can't Produce"

St. Louis, Dec. 1—Proposed federal health insurance is more a political maneuver than an honest answer to the nation's health problems, Dr. Maurice H. Friedman, Washington, told physicians at the national grass-roots conference at the A.M.A. interim session.

Hospital Needs Distorted

Doctor Friedman charged that Federal Security Administrator Oscar Ewing's ten-point health program paints a darker picture than necessary. "And there is no justification whatsoever for promising our people miracles which cannot be produced, even by an astonishingly successful politician," he asserted.

The statement that 40 percent of U. S. counties are without an adequate general hospital does not supply a true picture he said. "The county is a poor unit by which to measure the adequacy of health services," he explained. "But it is a politically useful one."

No Evidence

"Are we to permit the federal government to take over one activity after another until we have no private enterprise left?" Dr. Friedman asked. "Is there satisfactory evidence that the government can do everything better, more efficiently, with greater satisfaction to the individual and at lower costs?"

Volunteer or Be Drafted, Sargent Warns Doctors

Army Still Needs Medics

St. Louis, Mo., Dec. 1—Young doctors have been warned to prepare for a special draft into the armed forces, if physicians do not volunteer in sufficient numbers, declared Dr. James C. Sargent, Milwaukee, speaker at a grass-roots conference at the Interim session of the A.M.A.

Doctor Sargent declared that the armed forces still do not have enough physicians to meet their needs, and that the question of a special draft is "entirely up to the group of youngsters who were deferred during the recent war in order to study medicine."

Uphold Dignity

Dr. George F. Lull, secretary-general manager of the A. M. A. told the meeting that young physicians have a responsibility to "uphold the dignity of the medical profession and enlist."

He added that many young doctors are staying out of the armed forces on the principle: "We don't know what they are going to do, so we will let them come and get us."

Brig. Gen. George E. Armstrong, deputy surgeon general of the United States army, said that medical problems which would result from an atomic bomb attack would require physician experts to tell the people "where you can go, how you can go and how long you can stay," because of radio activity, and that blood, antibiotics and other medical supplies may be used only for those casualties who have a chance to live.

Up to Local Draft Boards to Decide on Deferment Of Medical-Dental Students

Washington, D. C., Nov. 15.—In a memorandum sent to all state selective service directors, Maj. Gen. Louis B. Hershey, national selective service director, recommended deferment of medical students to assure the nation an adequate supply of physicians, dentists and "other medical practitioners."

The policy affects 44,000 students in medical, professional or pre-professional schools. Similar policies will be established by scientific students.

Undulant Fever More Serious Than Polio

Dr. Stuessy Also Praises Wisconsin Plan

Madison, Nov. 16—Undulant fever presents a problem more serious to rural people than polio, and its ravages will probably not be stopped until all cattle in the state are Bang's-tested, Dr. M. W. Stuessy, Brodhead, told nearly 200 members of the Associated Women of the Wisconsin Farm Bureau at their annual meeting.

Declaring that the mysteries of undulant fever are still not fully explained, Doctor Stuessy pointed out that there are about 40,000 active cases, and some 4,000,000 dormant cases, in this country.

Doctor Stuessy explained the Wisconsin Plan of prepaid surgical, obstetrical and hospital care which the Farm Bureau is sponsoring for its members through county health improvement associations set up by wives of members.

He explained that such insurance plans are vitally needed by the people of Wisconsin to help them budget their medical care expense, and that they are the best answer to compulsory medicine.

Under a system of national health insurance the quality of medical care would decline he said. "Most of us have experienced bureaucracy costs, with the higher taxes involved," Dr. Stuessy said. "Most of us feel that the problems we can take care of ourselves are done better and more economically. We don't like to see federal snoopers coming around and giving us advice. If the government takes care of the sick it will be just one more bureau and one more enormous expense."

Propose Point System For Doctors' Service

Winston-Salem, N.C., Oct. 28.—A point system for the selection of physicians for service in the armed forces has been recommended by the Forsyth County Medical Society Military Affairs committee.

The point system was one of the points suggested in its recommendations to the American Medical Association asking that the Council on National Emergency Medical Service make every effort to provide for the efficient use of medical personnel in the armed forces and obtain assurance that any doctor now in civilian life who may apply for a commission or active duty will be allowed to return to civilian life after completing two years' service.

Farm Areas Considered

The point system would operate as follows:

Men with the lowest number of points should be the first to apply for a commission and/or active duty for two years. Five points should be allowed for each year of age, fifty for each minor dependent, ten for each month of military duty and five for each month of foreign military duty.

Twenty points should be subtracted for each month of education or training of college quality at government expense during active duty and five points for each month subsequent to active duty.

Exemptions would include those 45 years of age or over, the physically disqualified, physicians needed in rural communities which would be left without adequate medical care, heads of departments of medical schools, interns and residents until completion of their studies.

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NEARLY 100,000 PERSONS COVERED BY WISCONSIN PHYSICIANS SERVICE

$425,000 Paid in Claims; $49,500 in Reserves

Madison, Dec. 4—More than 95,000 persons are now covered by the Wisconsin Physicians Service plan of medical and surgical benefits, reports Ralph F. Weber, director of WPS.

With the present rate of enrollment, Mr. Weber said that he expected coverage to reach 100,000 by the end of the year. In the past 17 months, more than $425,000 has been paid out in benefits for subscribers.

No Huge Reserves

Premium income for this period is reported at $585,259.94 with physicians' claims paid and accrued standing at $425,151.25, he said. Mr. Weber reported that $49,500.33 is now available for reserves, including funds for maternity, disaster and unforeseen contingencies. This is in addition to the capital investment of $20,000 from the State Medical Society, he declared.

In the operation of non-profit plans, Mr. Weber pointed out, the purpose is to operate as soundly as possible without building huge reserves.

Mr. Weber said that he has been greatly encouraged by the rapidity with which doctors are returning their physician's service report forms. This enables the plan to pay bills promptly and with the least administrative expense.

He pointed out that when anesthesia is rendered by a doctor other than the attending physician or a paid employee of a hospital, the physician's service report form should include the name of the doctor anesthesiologist. The attending physician should supply this information on the form.

"Not Too Much Expected" From 7 M. D.'s in House

Washington, D. C., Nov. 8.—All seven physician members of the House of Representatives are opposed to compulsory health insurance, and all were reelected, declared Gerald Gross, editor, Washington Report on the Medical Sciences.

"Not too much can be expected of them," he said, "as none is a member of the House Interstate and Foreign Commerce Committee which will handle health insurance."

Murray on Committee

This committee will probably be reorganized in view of Democratic control of the House, Mr. Gross stated, and the new chairman will likely be Rep. Robert Crosser, Ohio, son of a country doctor and brother-in-law of two physicians. Mr. Gross said he expected that eight Democrats and no Republicans would be added to this committee.

In the Senate, the subcommittee on health is almost certain to be directed by Sen. James E. Murray, Gross reported. He added that there "is every reason to believe that a bill for compulsory health insurance will be favorably reported before the first session of the new Congress is many months old."

Physicians Warned Of Dangerous Drugs

Chicago, Oct. 9.—The Federal Security Agency's Food and Drug Administration warns physicians and dentists that certain codes of procaine hydrochloride solution manufactured by C. B. Kendall Company, Indianapolis, Indiana, caused severe necrotic damage upon injection.

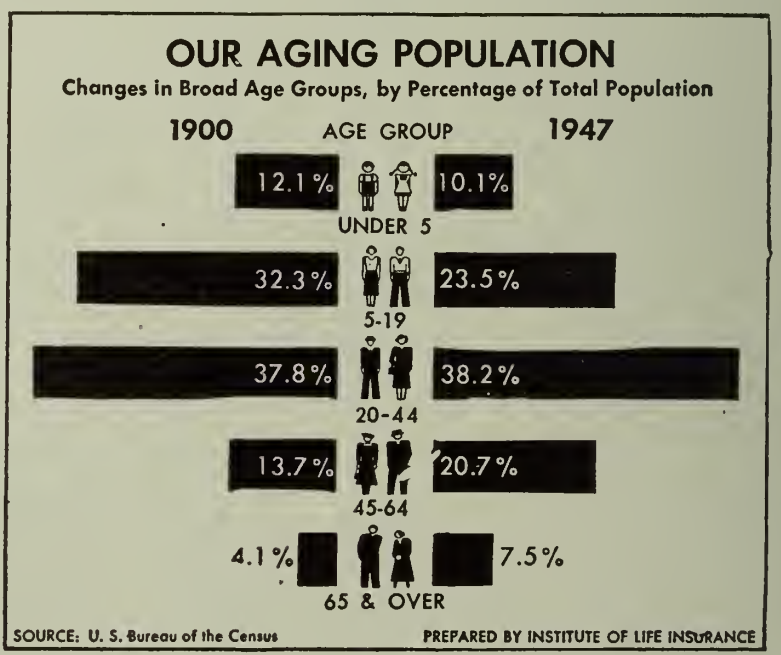
The company has attempted to recall all vials of this solution which are coded 24830 and 64712. This recall program has not been completely effective.

Distributed in State

Reports indicate that much of this product has been distributed in the Wisconsin area.

The A. M. A. also reports that the following injection products of C. B. Kendall Company have low pH values:

Vitamin B Complex Stronger; Vitamin B Complex; Thiamine Hydrochloride; Pyridoxine Hydrochloride; Pentabexin and Procaine Hydrochloride.



WISCONSIN'S POPULATION shows an even greater aging trend than the rest of the nation which is indicated above. More than 280,000 Wisconsin residents are now 65 years of age or over and the number increases at least 5,000 persons each year. The proportion of our population over 65 has jumped from 5% in 1900 to 8.7% in 1948 and is expected to reach 12% by 1947. At least 9,000 of those now over 65 need infirmary type care.

Magnuson Explains How VA Fees Are Set for Home-Town Physicians

Washington, D. C., Oct. 14.—The establishment of fees to be paid physicians working under the Veterans Administration home-town medical program has been explained by Dr. Paul B. Magnuson, chief medical director, as follows:

"It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so called 'Home Town Medical Care Program for Veterans.' It has been contended that the Veterans Administration has arbitrarily established a Fee Schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a National Fee Schedule. It has also been contended that the various State Medical Societies and other interested groups were not consulted when this Fee Schedule was adopted.

No National Fee Plan

"In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a National Schedule of Fees, nor do I contemplate doing so. However, the Fee Schedules originally submitted by the various State Medical Societies, when the 'Home Town Medical Care Program' was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform Fee Schedule Format and to set up tentative fees which could be used as a guide by the various State Medical Societies when submitting their proposals for the furnishing of medical care to veterans.

"This uniform Fee Schedule Format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This Group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after a careful analysis of Pre-Paid Medical Care Plan, Workmen's Compensation and Insurance Fee Schedule, and also the Fee Schedules in effect in the various States having agreements with the Veterans Administration. As was to be expected, considerable variation occurred in the Fee Schedules reviewed.

"The Professional Group of National Consultants made every effort to arrive at fees that were considered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between State Medical Societies and the Veterans Administration.

"Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation 'AA', which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the Medical Society concerned.

"May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or National Fee Schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate."

Doege Announces 1949 Committee Appointments

48 Doctors Chosen for Terms

Milwaukee, Oct. 5—President Karl H. Doege, Marshfield, has appointed the following physicians to fill committee terms which expire in 1948:

Committee on Cancer, Dr. W. S. Bump, Rhinelander, chairman; Dr. J. W. McGill, Superior, Dr. J. D. Wilkinson, Oconomowoc; Dr. J. W. McRoberts, Sheboygan and Dr. M. H. Steen, Oshkosh.

Care of Crippled Children—Dr. H. A. Sincock, Superior, chairman, and Dr. C. M. Kurtz, Madison.

Coordination of Medical Services—Dr. S. B. Harper, Madison, chairman, and Dr. S. E. Gavin, Fond du Lac.

Goiter—Dr. A. S. Jackson, Madison, chairman.

Grievances—Dr. R. E. Fitzgerald, Milwaukee, chairman.

Health and Public Instruction—Dr. Norbert Enzer, Milwaukee, chairman, and Dr. L. R. Cole, Madison.

Hearing Defects—Dr. W. E. Grove, Milwaukee, chairman; Dr. T. L. Tolan, Milwaukee, Dr. W. W. Ford, Green Bay and Dr. G. B. Ridout, La Crosse.

Hospital Relations—Dr. A. J. McCarey, Green Bay, chairman, and Dr. J. E. Habbe, Milwaukee.

Industrial Health—Dr. D. E. Dorchester, Sturgeon Bay, chairman.

Maternal and Child Welfare—Dr. W. C. Stewart, Kenosha, chairman; Dr. L. M. Simonson, Sheboygan and Dr. J. W. Harris, Madison.

Medical Economics and Voluntary Sickness Insurance—Dr. Robert Krohn, Black River Falls, chairman; Dr. H. B. Norveil, Phillips and Dr. L. J. Bayer, Merrill.

Medical Education and Hospitals—Dr. T. L. Squier, Milwaukee, chairman and Dr. J. E. Gonce, Madison.

Council on Medical Service and Public Relations—Dr. R. G. Arveson, Frederic, chairman and Dr. C. R. Marquardt, Milwaukee.

Mental Hygiene, Institutional Care, Public Welfare and State Departments—Dr. H. H. Christofferson, Colby, chairman, Dr. B. J. Hughes, Winnebago; Dr. W. A. Munn, Janesville, Dr. P. R. Minahan, Green Bay and Dr. O. H. Epley, New Richmond.

Public Policy—Dr. C. A. Dawson, River Falls, chairman; Dr. J. M. Sullivan, Milwaukee, Dr. J. K. Curtis, Madison, Dr. S. E. Gavin, Fond du Lac and Dr. H. H. Christensen, Wausau.

Rural Health and Accident Prevention—Dr. R. L. MacCornack, Whitehall, chairman and Dr. M. W. Stuessy, Brodhead.

Council on Scientific Work—Dr. T. O. Nuzum, Janesville.

Tuberculosis and Chest Diseases—Dr. L. O. Simenstad, Osceola, chairman and Dr. A. A. Pleyte, Milwaukee.

Visual Defects—Dr. J. B. Hitz, Milwaukee, chairman.

Reappraise the Wisconsin General Hospital Law—Dr. G. W. Carlson, Appleton, chairman; Dr. L. R. Cole, Madison, Dr. Peter Midelfart, Eau Claire, Dr. H. E. Kasten, Beloit and Dr. J. C. Fox, La Crosse.

PUBLIC RELATIONS IN PRACTICE

Dr. Beebe — Citizen . . . "Outstanding example of a public spirited individual is Dr. Spencer D. Beebe of Sparta, whose participation in civic activities has not lessened through the years." This is the tribute paid him by the La Crosse *Tribune*, for his medical leadership, his sponsorship of outdoor nonsectarian religious services and his paid "public debate" advertisements in Sparta Newspapers. The editorial continues: "Dr. Beebe at least is one individual firm enough in his convictions to pay to express them, convincing proof of his sincerity. His past deeds in civic line stamp him as an outstanding citizen."

PR–PR–PR–PR

Stumping for the Profession . . . More than 60 persons heard Dr. L. B. MacLaren, Appleton, on Nov. 10 when he talked before the Neenah–Menasha American association of University Women on the subject of "Rheumatic Fever."

PR–PR–PR–PR

For the Public Interest . . . Dr. H. E. Gillette, Pardeeville, recently appeared before the county board as a representative of the Columbia county medical society in their effort to secure the employment of a psychiatrist in the county and the establishment of a child guidance clinic.

PR–PR–PR–PR

Public Relations with Polio . . . Dr. Geo. E. Bryant, Menomonie, recently described the stages of polio to the Parent–Teachers group in his city. He had just returned from the University of Wisconsin Polio clinic. That's putting science and art together for better public relations.

PR–PR–PR–PR

PR in Mental Health—The doctors of Brown–Kewaunee–Door county medical society did the public and the profession a good PR turn when they sponsored an open panel discussion on mental illness at the Green Bay high school on Dec. 7. The public needs to be reassured that their good health is the profession's major goal.

PR–PR–PR–PR

What Other States Are Doing . . . Louisiana State Medical society has worked out a school health council program with their state department of education, PTA, nurses association, superintendent's group, and dental society calling for instruction of teachers in health services; screening of all children by teachers; medical and dental care by family physicians, and complete physical exams for all first grade children.

PR–PR–PR–PR

Indianapolis . . . The local medical society offers its services in helping newcomers to the city get a family physician as soon as they move into town. At least 1,200 families a year will be contacted.

PR–PR–PR–PR

Michigian . . . A committee of the Michigan State Medical society will soon meet with the deans of two medical schools, the Governor and with Senate and House appropriations committees to investigate possibilities of increasing the number of medical graduates from schools in that state.

PR–PR–PR–PR

Pennsylvania . . . Suggests that each county medical society contact its local Chambers of Commerce to inform new residents in the community to get in touch with the county medical society for help in selecting a family physician.

PR–PR–PR–PR

Farm Bureau Praises Wisconsin Plan; Seeks State Lab of Hygiene

Madison, Nov. 16.—Opposition to socialized medicine, praise for the work of the State Board of Health's hospital construction plan, and support for an expanded state laboratory of hygiene, were among the policies outlined by Farm Bureau members at their annual meeting here.

To assure rural people of better hospital and medical facilities, the delegates passed the following resolutions on health:

"We commend the State Hospital Committee on the excellent job that it has done in developing a projected program of hospital construction in the state.

"We support the State Public Health Council and extend our cooperation.

"We are gratified with the exceptional growth and expansion of the Hospitalization Insurance Program (The Wisconsin Plan) and pledge support to its further expansion.

"We recommend adequate state appropriations to establish and maintain a well-equipped state laboratory of hygiene.

"We recommend that we study the report made by the joint committee on juvenile deliquency and work with interested legislators to secure necessary appropriations to enable our state to provide adequate housing and medical care for handicapped children of our state.

"We oppose socialized medicine and favor expansion of group hospitalization and health programs on a voluntary basis."

The Farm Bureau health program is being developed under the direction of Mr. Harold Kautzer, Madison.

Most Doctors Would Reject Compulsion

Would Refuse to Serve

Rutherford, N. J., Oct. 4.—Sixty-one per cent of physicians in private practice in the United States would refuse to provide service under the proposed Wagner–Murray–Dingell bill, it was reported by William A. Richardson, editor of *Medical Economics*, national business magazine for doctors.

In response to a query "Would you participate in the Wagner–Murray–Dingell program if it became law?" replies from 4,864 M. D.'s showed that 61 percent voted "no"; 15 per cent voted "yes"; and 24 per cent said they were "undecided."

City M. D.'s More Favorable

"In short, the great bulk of the profession, while continuing to treat patients privately, will stand aloof from any such Federal compulsory program," he said.

The survey showed that doctors in larger cities are more tolerant toward a Wagner plan than those in smaller places, physicians in the higher income brackets are most adverse to the program, and older physicians oppose the plan more vigorously than their younger colleagues.

(Continued from page 1206)

that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

7. Losses by fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

8. Medical Conventions. Ordinary and necessary expenses incurred in attending medical conventions of professional scientific societies, necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

9. Medical Supplies and Instruments (See paragraph 4, page 1200).

10. Office Expenses (See paragraph 5, page 1201).

11. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

12. Professional Dues. Professional dues paid to professional associations to which the physician may belong in the interest of his profession may be deducted.

13. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.
(b) Personal property taxes paid on his apparatus and equipment.
(c) Wisconsin income taxes and surtaxes paid.
(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum deduction not to exceed 3 per cent of net income computed under the state law *before* contributions.
(e) All license fees incident to his profession.
(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.
(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.
(h) All social security taxes paid by the physician under Titles VIII or IX in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. A salaried physician, under a new rule, is required to add the amount of the social security tax paid by him to his net salary received for purposes of determining gross income. He is then permitted by by the same rule to deduct the amount of the social security tax withheld from him and to include it as part of his federal income tax, subject to the 3 per cent maximum rule noted in subhead (d) above.

14. Traveling Expenses (See paragraph 9, page 1201).

15. Wages and Salaries (See paragraph 10, page 1201 and 16(e) below).

16. Miscellaneous.

(a) Laboratory Expenses (See paragraph 11(c), page 1201).
(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

Legal expenses incurred in connection with the operation of a taxpayer's profession

are proper deductions unless such business is conducted in violation of the law.

(c) Sale of Spectacles (See paragraph 11(e), page 1202).

(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an office and organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

(f) Contributions or gifts made to public, religious, educational, charitable, veteran's, or other groups listed in section 71.05 (6) are deductible to an amount not in excess of ten per cent of the taxpayer's net income for the fiscal or calendar year.

(g) Medical expenses—payments in excess of $50 but not over $500 for hospital, nursing, medical, surgical, dental services and medical supplies incurred by the taxpayer on account of illness or of personal injury to himself or his dependents.

Importance of Adequate Accounting Records

It is equally true under both the federal and the Wisconsin laws that a properly maintained set of double-entry accounts is probably the greatest single means of facilitating the preparation of a physician's income tax returns, and of enabling him to secure the maximum advantage from the exemption and deduction statutes. Such a bookkeeping system is neither complicated nor unreasonably time consuming. It can be installed by any competent accountant at a reasonable cost, and can be maintained by any trained bookkeeper. A large number of tax complications would never arise if adequate accounting records were available to serve as the basis of tax returns, or as the authority for settling questions at an early stage.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES BROADCAST OF SCIENTIFIC LECTURES BY WHA-FM

Undoubtedly one of the most significant steps in postgraduate medical education is being taken by the University of Wisconsin Medical School with use of the frequency modulation facilities of the University of Wisconsin radio station, WHA, in presenting, from time to time, conferences, symposia, and medical lectures focused primarily for the medical practitioner of Wisconsin.

Arrangements are being made with Station WHA in Madison for the use of a one or possibly two hour night period for broadcast of this type of scientific program. County medical societies will be contacted, and local arrangements will be made for frequency modulation reception.

This is the first time that scientific medical material has been broadcast by a medical school through a state-owned university radio station. The first program will probably be given in February 1949, and it will concern the human back. Subsequent programs are being planned to include thoracic diseases, newer theraputic methods, and similar topics.

Transactions of the 1948 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Sunday, October 3, 1948

The opening session of the House of Delegates of the State Medical Society of Wisconsin held in connection with its One Hundred and Seventh Annual Meeting at the Hotel Schroeder, Milwaukee, convened at 2 p.m., Dr. Gunnar Gundersen, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials, composed of Drs. G. W. Carlson, Appleton, chairman; J. W. Fons, Milwaukee; and D. J. Twohig, Fond du Lac, reported the registration of forty-six delegates and eight alternate delegates entitled to vote. In addition, six alternate delegates and two councilors were registered. Doctor Carlson moved acceptance of the report; seconded by Dr. E. C. Cary, Reedsville, and carried unanimously.

Minutes of the 1947 Regular Session Approved

The proceedings of the 1947 House of Delegates as published in the December 1947 issue of *The Wisconsin Medical Journal*, were unanimously approved following a motion by Dr. W. C. Stewart, Kenosha, seconded by Dr. E. L. Bernhart, Milwaukee.

Adoption of Standing Rules

On motion of Dr. R. L. MacCornack, seconded by Dr. C. M. Echols, the following were constituted the standing rules for the 1948 session:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the proviso that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.

Excerpts from the Report of the Speaker

Speaker Gundersen: I desire to address myself to a few matters which I regard to be of some moment.

First, to turn briefly to a matter of legislative importance. After the First World War there was built in Madison the Wisconsin General Hospital, a memorial to the men who fought, and many of whom died, in that war. It came to be and is the teaching hospital of the University of Wisconsin Medical School.

In order to devise ways and means of paying for the patients who seek care in this hospital under the teaching staff of the medical school, there was enacted the so-called Wisconsin General Hospital Law. One of the provisions of the Act prescribes how the hospital is to be compensated for care rendered to the indigent by the referring counties, e.g., one-half from state funds and the remaining one-half from the funds of the referring county. The per diem necessarily fluctuates depending upon operating costs, from an average of $4.96 per day for many years, to the present level of approximately $12 per day.

One of the purposes of the Act originally, in addition to furnishing skilled care which otherwise could not be provided elsewhere, was to insure usage of the facilities for the purpose of teaching medical students, and also to encourage utilization of a new institution by referring county judges. This is all as it should be. Tied up with the Act, however, lies discretionary authority in a county judge to order hospitalization at home, if such hospitalization shall not result in a greater cost to the referring county.

In effect, this law results in the FIXING of charges which local counties are willing to pay local hospitals for care of its indigents and, furthermore,

establishes in many instances the going county rate for hospital care by counties in local institutions.

The law results in crowding the Wisconsin General Hospital often with valetudinarians whose value for teaching purposes may well be open to question and who might better be cared for closer to home, with the Wisconsin General Hospital bulging at the seams. Conditions are often so congested that it is with greatest difficulty that important emergency cases can gain admittance, if indeed they can be admitted at all. The law furthermore has the undesirable effect of tending to centralize the hospitalization of all the indigent sick in the state (outside of Milwaukee County) in Madison. This is neither intelligent nor desirable.

There should be no tie-up between the cost of care at the Wisconsin General Hospital and the cost of care for indigents at hospitals generally throughout the state. The time has come, in the opinion of your Speaker, when a reappraisal of the law is in order for the purpose of rectifying this anomaly. The question is of sufficient importance to be referred to a special committee of the Society for study, with the view of redrafting the law at the coming legislative session.

A special committee might well be appointed forthwith by the incoming President. Representation on the committee should include men of broad public interest from the University of Wisconsin Medical School as well as the state at large. In the committee should be vested authority to act upon its suggested reform after consultation with and approval of the Council of this Society so that remedial legislation may be enacted at the coming session of the legislature.

Prepayment Medical Care Plans.—That *adequate medical care* is to a great extent an economic problem, no one would seriously question. That a certain segment of society, the mentally ill, the tubercular, the indigent, the chronically ill, and so on,—all told relatively a large per cent of the population,—should properly be and is a charge on society, is now accepted as sound social planning; but, as far as the productive segment of society is concerned, it is my considered judgment that the vast majority of this group is desirous of doing for itself if it be given an opportunity to do so.

In this connection it is heartening that our own inspired prepayment medical and hospital care plans, be they of the service type or the cash indemnity order, are growing daily, so that in Wisconsin now upwards of 600,000 to 700,000 of its people are covered by a Blue Cross type of plan, and 400,000 by a Blue Shield type of coverage. Our duty as physicians in the economic field of medicine should be to preach the gospel of budgeting for sickness by giving encouragement to the development of these plans so that the saturation point, as far as coverage goes, be it in one plan or the other, shall be reached in a minimum of time. This would at least be a weighty answer to those who would have centralized government authority seek to do it for us.

We are in an election year, so it is by nature a time when most of us at least are giving some consideration to matters of state. Not so much, perhaps, those of us who spend most of our time (if not all of it) ministering to the sick who come under our care as those who are in the full-time business of "politics," and I use the word "politics" advisedly and in its charitable connotation.

The year has been important if for one reason only, because it was highlighted by a National Health Conference held in Washington early in May, called by Federal Security Administrator Oscar Ewing, at the request of President Truman, for the purpose of outlining health goals for the next ten years.

The result of the Assembly was what everyone "in the know" predicted it would be. Interestingly enough, the report entitled "The Nation's Health," a ten year program by Mr. Ewing, transmitted on September 2 to President Truman, was not an objective report by a disinterested reporter, but Mr. Ewing's private interpretation of the high lights of the Assembly. In fact, it has been said by many in a position to know that his report and recommendations were prepared and written even before the Assembly had gotten under way.

The essence of the Truman–Ewing Health Program is the creation of a national compulsory medical care insurance system, which would be augmented by a greatly expanded program of medical education and research, hospital construction, hospital maintenance, and community health protection. The document, 186 pages printed at government expense, appears opportunely as a first-class campaign document, politically conceived, politically engineered, and politically timed.

Ewing has received and gathered together all the old stuff that has been repeatedly advanced in support of a national health insurance program, and has added some material taken from recent committee reports. He has overlooked the great advances that have been made in the improvement of our national health by the people themselves, and remains merely a staunch advocate of a paternalistic government.

Turning for a brief moment to the other side of the political fence, there is small comfort to be gained by finding in the number two spot on the Republican slate a man who, on the basis of his record, has made every effort to "outdeal the New Deal." It is unfortunate, in the opinion of your Speaker, that the American people in their social thinking have come to a point where they are looking more and more to a centralized authority, on a national as well as a state level, to do for them what people could and should be doing for themselves.

Private and individual initiative are the elements which have made this great nation. Is there any reason now, after having successfully weathered the onslaught of a second World War in your and my lifetime, to capitulate to an "ism" which is totally

foreign to the philosophy which has made this country great?

I ask the question.

American medicine, in its glorious records, as evidenced by its unexcelled public health achievements, has succeeded by reason of the private initiative system. Organized medicine is not yet ready to surrender to political domination.

SUPPLEMENTARY REPORTS AND REPORTS OF OFFICERS

Supplementary Report of the Council

Activities of the Council are reported periodically in *The Wisconsin Medical Journal.* Minutes of its meetings are contained in considerable detail, and interested physicians should have little difficulty in following its work. In addition, the following supplementary report was submitted:

1. Committee on Venereal Diseases.—The Committee on Venereal Diseases serves essentially as an advisory committee to the State Board of Health, through which agency the responsibility for the control of venereal disease rests. During the past year the committee has been asked to consider a proposal to have free penicillin furnished individual practitioners for the treatment of venereal disease, under newly established rapid treatment procedures. It has been further suggested that emphasis be placed on rapid treatment through the individual practitioner, rather than meeting the demands of venereal disease control through the operation of treatment clinics.

The committee is impressed with the fact that the operation of the clinics for the control of venereal disease is costly without making an appreciable effect upon the reservoir of venereal diseases in the state. It is recommended by the committee that during the ensuing year the operation of the various treatment clinics be analyzed with care, and that further recommendations be transmitted to the House of Delegates or to the Council as soon as possible.

The committee at this time is not prepared to recommend the distribution of penicillin without controls as to its use, so that the drugs so supplied will be used in treatment procedures outlined for the improved treatment of venereal disease.

2. Conference Committee on Open Panels.—This report shows the distribution of more than 50,000 panels of physicians available for the care of those injured under compensable circumstances. This program will be continued along the lines indicated.

3. Committee on Military Medical Service.—In part, this report urges the State Society to maintain its current inventory of physicians, recommends conference with the Governor to accomplish an adequate program in civilian defense, asks that each county medical society establish local procedures for military and disaster medical service, and, if an inadequate number of physicians is available for military service through customary means, suggests that those physicians who obtained all or part of the training under either the A.S.T.P. or the V–12 program should be made available.

4. Wisconsin Veterans Medical Service Agency.—The report of this committee of the Council, transmitted in full to the House, details the activities of the agency and the volume of authorizations handled by it in providing the veterans with home-town care.

5. Committee on Extension of Insurance.—This committee is in charge of the direction of the Wisconsin Plan. Its report, also directed to the House in full, details operation of the program since it was placed in operation.

6. Life Membership.—The Council directs to the attention of the delegates its concern with reference to the extension of life membership. A strict reading of the present Bylaw provision (Chapter VIII, Section 1, second paragraph) indicates that a member who meets the qualifications of either (1) having attained his seventy-fifth year and having been continuously a member of his county medical society in Wisconsin since beginning the practice of medicine; or (2) having been continuously a member of his county medical society in Wisconsin for forty years is thereby ordinarily entitled to life membership. The Council is of the belief that in the enactment of this Bylaw, as amended in the 1947 session, it was intended by the House that the Council use its discretion in the extension of this honor to various members.

The Council is of the belief that there should be meritorious cause in connection with this award. If the House believes that life membership should be predicated upon such an interpretation, the second paragraph of Section 1 of Chapter VIII should be amended.

A proposed amendment follows, with deletions indicated by words in brackets and additions in boldface.

"An active member who shall have attained his seventy-fifth year and shall have been a member of his county medical society in Wisconsin continuously since beginning the practice of medicine, or who for forty years shall have been continuously a member of his county medical society in Wisconsin, **may** [shall], upon establishing the above facts to the satisfaction of his county society, [and] upon the recommendation of such society, **and upon finding of the Council of meritorious service,** be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him [annually]."

7. The Council is in receipt of a resolution adopted by the House of Delegates of the American Medical Association. This resolution recommends that state medical societies accept the obligation of paying the state and national dues of their auxiliary members. The Council forwards this resolution to this House for appropriate action, adding its own recommendation that it be approved. It reads as follows:

Whereas, our local, State and national woman's auxiliaries have became an indispensible adjunct of organized medicine, and

Whereas, the local, State and national auxiliaries are especially effective as agencies for furthering the education of the public concerning the aims and accomplishments of scientific medicine, and

Whereas, their maximum effectiveness requires participation by the wife of every member and sufficient funds to enable them to carry on their essential activities; therefore be it

Resolved: That each constituent State medical association be urged to budget sufficient funds to defray the cost of the activities of its auxiliary and to pay the annual dues of the national auxiliary, thus making the wife of every member automatically a member of the State and national auxiliaries and eliminating the collection of state and national auxiliary dues from individual auxiliary members.

8. The delegates have been advised of that provision of the Bylaws requiring advance submission of resolutions to be considered by the House. An exception is granted to certain official bodies, including the Council. During this morning's session the Council was asked to introduce two resolutions to this House by representatives unable to do so themselves, in view of the Bylaw mentioned. The Council acceded to these requests, and offers the following resolutions without expression of opinion:

Whereas, at the June 1947 meeting of the American Medical Association in Atlantic City, the Council on Medical Service of the AMA ordered a six-man committee, three to be selected by the President of the Medical Society of Milwaukee County and three by the President of the State Medical Society of Wisconsin, for the purpose of forming a single prepayment plan for the State of Wisconsin, and

Whereas, this Committee has labored for almost one and one-half years, and

Whereas, the three physicians from the State have asked Dr. Stovall to accept their resignations because the entire Committee is deadlocked and their release from the Committee has been accepted, and

Whereas, this above fact places the controversy back where it was before June 1947, and

Whereas, unity of the entire medical profession is more important than any plan of prepaid medical insurance; therefore, be it

Resolved: That the House of Delegates approve the following compromise as a practical solution to this controversy:

1. That the House of Delegates give its approval to the Surgical Medical Care plan as governed and conducted by the Board of Directors of Milwaukee County.

2. That Surgical Medical Care be sold only in Milwaukee County.

3. That Surgical Medical Care cancel and/or transfer all of its contracts outside of Milwaukee County on or before December 1, 1948.

4. That Surgical Medical Care turn over to Wisconsin Physicians Service enough money to cover the maternity benefits on the transferred or cancelled contracts or that this money be put in escrow for those benefits.

The second resolution is by Dr. L. O. Simenstad:

Whereas, there has been an extension of endorsed voluntary prepaid medical care plans to an increasing number of individuals, and

Whereas, particularly in the rural communities the organization of groups to purchase this type of protection is difficult except as to a limtied number, and

Whereas, the cooperatives are endorsing and developing projects for the delivery of medical, surgical and hospital care, through cooperatives especially organized for that purpose, and

Whereas, Wisconsin Physicians Service represents the State Medical Society's own effort in this field, but it is as yet available only to groups of five or more; be it therefore

Resolved: That the Directing Board of Wisconsin Physicians Service be urged to make an immediate study of the feasibility, cost, and contract provisions of making coverage available to individuals and non-group families, and to report that study to the Council for further consideration at the earliest practical date.

[The Supplementary Report of the Council was referred to the proper committees, that part dealing with resolutions to the Committee on Resolutions and the balance to the Reference Committee on Reports of Committees.]

Excerpts From Report of the President

President W. D. Stovall: You undoubtedly know that a year as President-elect and a year as President do not make an administrative official. In fact, it would be unwise to expect anyone to come into the Presidency and assume administrative responsibilities. If he attempted to assume this function he certainly would make many grave mistakes. It is therefore his duty to meet with the committees and councils; to join in their discussion and give freely of his advice if he has thought on the subject and is familiar with it. This policy I have followed, and have received from everyone the most cordial cooperation and support.

Your Society is run by a number of committees, each one of which is responsible for the duty which you have placed upon it. This is well illustrated in the various sickness insurance committees (Physicians Service, Wisconsin Plan, Wisconsin Veterans Medical Service, and so on), and the General Council. Here all matters of importance go for final decision.

However, the Council meets only four times a year. Affairs that are coming before the Society now are of such magnitude that no board, meeting four times a year, can give proper direction to the affairs of the Society or be of proper assistance to the Secretary in arriving at important decisions. The Council's Interim Committee serves excellently in this capacity. It meets once a month. During the past year this committee has functioned extremely well and has been of great service in managing the affairs of the Society. The Secretary, I am sure, from his comments to me, appreciates very much the assistance this committee has given him.

It is important to meet with lay groups and to attend local and district medical society meetings. I have met with as many of these groups as time would permit. I have considered it my duty, whenever possible, to accept invitations on programs for lay people where matters of interest to the profession were to be discussed.

There are some problems that are pressing which have great significance to both the public and the profession. One of them is the cooperative movement, which needs to be handled in a very careful and diplomatic manner. The cooperatives are large organizations; they are strong and have a great political influence. We, by careful and diplomatic consideration of the problem, can give direction to the thinking of the public.

The great cooperatives, like the great labor unions, become more interested in themselves and

their particular group than they do in all of the people. When their power becomes too great they are as great a menace as any other highly organized politically powerful group which is organized for the interest of one group.

If this country has been afraid of monopoly by corporations, certainly the trend of cooperatives is doubly disturbing. Those who have to be dealt with in these organizations are the leaders. The people themselves, by and large, are not informed on anything except the material advantages that they are promised. On this basis they follow the leader. Often the leader is promoting himself to power through the organization of his group.

However, there is a common meeting ground for all of these, and that is the interest of the public. Careful consideration and deliberate action can usually find a common ground in which the welfare of all interested parties can be perceived. At least it is worth while making the effort; and, if it cannot be accomplished by wise compromise then more stubborn opposition must be maintained.

The medical profession is confronted with another difficult economic problem—sickness insurance. We have differences among ourselves which can defeat the attempt to develop a system of sickness insurance through a guarantee of service by physicians. The wreck can be on the rocks of fee schedules. There are, no doubt, injustices in the present schedules, but there will be injustices in any schedule.

The question is not whether injustices exist, but whether agreement can be reached on a system of fees which will give satisfactory coverage to the low income group, and at the same time work the least hardship on those who must make some sacrifices. Compromise is inevitable. There is no such thing as justice to all. The consideration revolves around the degree of injustice. This we must settle. We do not have a choice of sickness insurance or no sickness insurance, but a choice of providing a sickness insurance that will be controlled by the profession, or a system that is devised and operated by others.

I cannot pass by this opportunity of calling your attention to a request by the Legislative Council that the State Medical Society assist and advise that Council concerning a report made last year on the organization and administrative practices of the State Board of Health.

We accepted this responsibility and immediately brought together a committee composed of two Wisconsin physicians, two men experienced in public health administration, one prominent in government planning, and one experienced in business management. The public health members were chosen from outside the state and because of their national reputation in the special fields of public health. This committee worked diligently for many months and has made a comprehensive report which has received the approval of the Legislative Council. Your Secretary showed fine leadership in this undertaking, and the office staff worked without stint on the preparation of the report.

Now it is my unpleasant duty to report to you on a matter which has long been a source of contention and disturbance to our Society. I wish it were possible for me to pass it by. I wish it could have been settled by the committee which was appointed to settle it; but since it was not, it is my duty to give you information on what has happened during the last year.

I refer to the settlement of the controversy with the Milwaukee County Society over a unified state-wide plan for sickness insurance. I want it clearly understood that I approached this question with no ill feeling, no bias, and no prejudice. I have been anxious for years to see this controversy settled, and, now that all efforts have failed, I am convinced that nothing will be accomplished by the further debate of it by the House of Delegates except that which is necessary for the disposition of the matter with the greatest dispatch, and which appears to be the most reasonable action at this time.

It is necessary for me to review what has happened since the lawsuit between the Medical Society of Milwaukee County and the State Medical Society was dismissed and the Council on Medical Service of the American Medical Association was asked to come in as mediator and arbitrator between the two societies. It is not necessary for me to go further back than that. All of the rest of the discussions and debates are familiar to all of you.

In June of 1946 a special session of the House of Delegates was called, and that session unanimously adopted a resolution creating a special committee instructed to report to the House in October a method for the establishment of a state-wide prepaid medical care plan. This plan was to provide a method for uniting Milwaukee Surgical Care and Wisconsin Physicians Service at the earliest possible date. This resolution is printed in full in the July 1946 issue of *The Wisconsin Medical Journal*, Medical Forum section, page 1.

This Committee reported in October 1946, and by final vote of 55:14 the House of Delegates accepted the majority report. This resolution is printed in full in the November 1946 *Wisconsin Medical Journal*, Medical Forum section, page 1.

The sequence of events since that time included the refusal of the Medical Society of Milwaukee County to agree to the absorption by the State Society of the Milwaukee Surgical Plan. At a meeting of the Council which began on January 26, 1946, a resolution offered by Doctor Witte was adopted, and information from Dr. U. A. Schlueter, the President of the Milwaukee County Society, confirmed its acceptance by the Board of Trustees of the Milwaukee County Society. The resolution was as follows:

Be it resolved: That, with the telegraphic or mail written approval of a majority of the members of the House of Delegates of the State Medical Society of Wisconsin and of the Board of Directors of the Medical

Society of Milwaukee County, the future of the Wisconsin Physicians Service Plan and the Surgical Medical Care Plan be placed in the hands of the Council on Medical Service of the American Medical Association. The two Societies agree to be bound by the decision of said Council on Medical Service.

Two members of the Council on Medical Service from the American Medical Association attended this meeting. These two members were Doctor McCormick and Doctor McVay. They accepted for the Council on Medical Service of the Americal Medical Association the responsibility of acting as arbitrator.

In June of 1947, at the meeting of the House of Delegates of the American Medical Association in Atlantic City, the American Medical Association Council reviewed the dispute between the Medical Society of Milwaukee County and the State Medical Society and then rendered its decision and the plan for terminating the controversy. Its decision was as follows:

"There are at the present time in the State of Wisconsin two prepayment plans, one known as Surgical Care of Milwaukee County, and the other known as Wisconsin Physicians Service. Many difficulties have arisen in the development and conduct of these plans. The problems seemed of such magnitude and so difficult of solution that the Council on Medical Service of the American Medical Association was asked by the parties concerned to arbitrate and make final settlement.

"Every member of the Council has studied carefully the brief presented by the Medical Society of Milwaukee County and the State Medical Society of Wisconsin. The Council has also heard oral presentations by representatives of both Societies citing the viewpoints of each.

"The Council has given earnest, serious consideration to the briefs and oral presentation, and decides as follows:

"1. That a new plan be formed comprising both the Wisconsin Physicians Service and the Surgical Care of Milwaukee County.

"2. That a new board of trustees be selected to take charge of this plan.

"3. And that these trustees be selected from all parts of the State, in proportion to the physician population.

"It is further decided that the central office of the new plan be in some area other than the cities where the offices of the two plans are now located; that all reserve funds now existing in the two plans be transferred to the new organization; that the contractural relations of subscribers to the present Milwaukee County Surgical Care Plan receive full protection of all their rights in the existing funds.

"That this be effected in accordance with the laws of the State of Wisconsin and the regulations of its commissioners of insurance.

"The Council further decides that a new executive director be employed to operate the plan, rather than employing directors of present plans.

"The Council further decides that a committee of six be formed, three of whom shall be selected by the President of the State Medical Society of Wisconsin, and three by the President of the Medical Society of Milwaukee County, and that this committee provide ways and means for the early selection of a board of trustees in accordance with the previous recommendations.

"The Council fully appreciates that both Societies have been actuated by the highest motives of bringing all possible aid in their power through prepayment plans to the people of the State of Wisconsin."

At that time I was President-elect of the State Society. President Dawson could not be in Atlantic City for the presentation of this report to representatives of the Medical Society of Milwaukee County and the State Society who were there assembled for the purpose of receiving it. Disappointment and dissatisfaction were expressed on both sides, but the fact remained that both societies had agreed to abide by the decision of this Council.

The important job now was to select a group of men without preconceived bias or prejudice because of participation in the controversy that had been going on for several years either by association with the operation of the Milwaukee Surgical Plan or the Wisconsin Physicians Service.

The next morning Doctor Schlueter and I expressed the desire to select a group of physicians who could attempt without prejudice the organization of the plan suggested by the Council on Medical Service. He and I agreed that this should be done by men who had previously had no connection with either plan.

When we returned to Wisconsin, I immediately informed President Dawson of the action of the Council, and he got in touch with Doctor Schlueter at once. They, in a letter addressed to the physicians of the State Medical Society under date of July 22, set forth the whole proceedings and named the six-man committee, three by President Dawson and three by President Schlueter. President Dawson nominated Dr. F. L. Weston, Madison; Dr. J. W. McGill, Superior; and Dr. W. S. Bump, Rhinelander, none of whom had previously been connected in any way with the controversy of the two societies and occupied no position on the State Medical Society's plan for sickness insurance.

Doctor Schlueter appointed Dr. A. C. Schmidt, Dr. G. S. Flaherty, and Dr. G. H. Wegmann, all of Milwaukee. Doctor Schmidt, at the time of his appointment, was a member of the committee of Milwaukee Surgical Care, and the other two became members of the Milwaukee Surgical Care after their appointment.

It appears that Doctor Dawson was more successful in obtaining the services of men who had previously had no connection with this controversy than was Doctor Schlueter in appointing his committee. This committee was unable to reach an agreement. On June 7, 1948, I received a letter from Dr. Frank Weston, asking that the committee be discharged, since it had not been able to find a satisfactory solution to the controversy.

Dr. Weston's letter read as follows:

I am addressing this letter to the five members of the committee, as well as a copy to you. The quite evident inactivity of the committee of six to which we were appointed by the President of the Milwaukee County Society and by you has now reached a point where I feel that the committee should be dissolved.

To bring us all up-to-date on our activities, I might remind you that we met first in Madison in mid-summer, 1947, had several meetings in Milwaukee, the last being in November, at which time I agreed to go to Chicago and discuss our problems with the American Medical Association group. This I did, and reported to you in my letter of December 22.

At that time I gave you as clearly as I could the attitude of the national group, and I offered at that time to get an attorney to work out a plan which could be presented to our group for discussion, change, or anything we wished to do with it.

At that time, by telephone conversation with Dr. Schmidt, the desire was conveyed to me that each of the two groups in the committee, that is, the three from Milwaukee and the three from the state at large, obtain legal aid to work out a plan for each side, so to speak. I personally did not feel that this was wise, for I thought that we were appointed as a committee unit, and I could not feel that a division of legal help would be very wise for us.

Because of that feeling I asked Dr. Schmidt, in telephone conversation, to proceed with what legal help he felt would be wise in Milwaukee, thinking that rather than delay further we should get some type of plan to work on.

Early in February I dropped a line to Dr. Schmidt, asking him if there was any action yet to be reported to the group, and was informed on the twelfth that there was nothing new, although he said at that time that he was going to call Porter to see if he had anything worked out for him. I assume that Porter was the attorney that had been decided upon by the Milwaukee contingent.

Now, of course, several months have passed and nothing more has come from Porter's work, and before we know it we will have been a committee appointed one full year without having accomplished anything.

I regret very much that we have not accomplished more. I still do not believe that this is a problem too difficult to solve, and I think that a totally impartial group could handle it very satisfactorily and very promptly to the satisfaction of both Milwaukee County and the State group.

F. L. Weston, M. D.

On August 9 I replied to Doctor Weston as follows:

For the past several weeks I have delayed replying to your letter of June 7, in which you ask for the discharge of the special committee appointed to devise a plan for combining the Milwaukee Surgical Plan with the State Medical Society's Physicians Service for sickness insurance. This delay has been occasioned by my disappointment at the failure of the committee to reach an agreement.

I am sure Dr. Dawson also will be greatly disappointed. The disappointment is made still greater by your statement: "I still do not believe that this is a problem too difficult to solve, and I think that a totally impartial group could handle it very satisfactorily and very promptly to the satisfaction of both Milwaukee County and the State group."

Dr. Dawson provided the committee with three men who had no personal ambitions and were entirely unbiased and unprejudiced in their approach to this problem. In spite of my disappointment, I am accepting your judgment, however, and discharging the State representatives on that committee.

Thank you all for your sincere effort in trying to bring to a satisfactory conclusion a problem that has been the source of so much conflict and dispute the last few years.

W. D. Stovall, M. D.

This gives you a complete review of affairs as they have happened since the matter was turned over to the Council on Medical Service of the American Medical Association. You have the comments of Doctor Weston for your consideration. I can see no reason for continuing the dispute. I am sure that Milwaukee County cannot expect the State Medical Society to continue to sponsor Milwaukee Surgical Care, since the State Medical Society has no voice and exercises no authority or influence in its plan.

Under these circumstances it seems to me advisable to make no further attempt to unify the Milwaukee Surgical and the Physicians Service plans on a state-wide basis. Past experience shows that it would mean more controversy and acrimonious debate which is not to the benefit of the Society; and, since the State no longer has a voice in the operation of Milwaukee County Surgical Care, it is my opinion that it, the State Medical Society, should withdraw, if that has not already been done, any further approval of the plan, and that the insurance commissioner be notified of this withdrawal.

At this point I want to make a personal explanation: This last statement is not put in here as any criticism. I have no feeling of resentment or spite anywhere in this Society, but I think we have an obligation to our state government when we have already advised with them concerning the setting up of these plans and had the permission of the commissioners to approve the plans with the approval of the commissioner, and that we as citizens of this state have an obligation to notify them of anything that has happened.

That is the only reason I suggested it, and certainly not to bring down any criticisms upon the Medical Society of Milwaukee County, and I hope no one will impute any such motive to it. I am honest when I tell you the thing that actuated me in placing this statement in this report. I don't think we can do anything else and still be fair with the commission and act as citizens in a free government.

This will permit Milwaukee to develop its plan along any line it likes, and it will leave the door open to unite with the State plan at any time that the Milwaukee County Society may decide to do so.

Excerpts from Address of the President-Elect

[The greater portion of the address of the President-Elect was published in the November issue of *The Wisconsin Medical Journal.*]

President-Elect Karl H. Doege: It is the privilege of the incoming President, at the fall meeting of the House of Delegates, to suggest appointees to the standing committees of the Society to fill expiring terms. In this connection I desire to make some recommendations with respect to the organization of several committees.

I wish to draw your attention especially to the splendid work done by the Committee on Hearing Defects in fact-finding and discovery of defects of hearing in children, not only in Milwaukee but in some of the outlying districts of the State. This work is of such splendid character that I definitely feel it could be enhanced by the addition of two more men on this Committee.

To accomplish the foregoing recommendation, I propose that the By-Laws of the State Society, Chapter VII, Section 19, be amended to read as follows:

The Committee on Hearing Defects shall consist of five members, and its principal duties shall lie in the field of prevention and, where existent, early discovery and treatment. It shall act in an advisory capacity to State departments concerned with these problems. Appointments to this Committee in 1948 shall be for three, four and five year terms, and appointments thereafter shall be for a term of five years.

I feel definitely that the activities of the Committee on Medical Education and Hospitals could be greatly enhanced by the addition of the deans of our two medical schools as members of this Committee. It is my recommendation that the deans of the two medical schools should be actual members of the Committee on Medical Education and Hospitals. To accomplish this recommendation, Chapter VII, Section 6 of the Bylaws should be amended by the following:

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

I feel that the activities of the Committee on Mental Hygiene and Institutional Care, and the Special Committee Advisory to the Department of Public Welfare and State Departments, and their personnel, greatly overlap. I feel that these two committees could very well be consolidated into one, and that one such committee could very well carry on the function of both.

In order to accomplish this I would suggest the addition of two more members to the Committee on Mental Hygiene and Institutional Care, and that its name be changed to indicate inclusion of Public Welfare and State Departments. To accomplish this recommendation I recommend that Chapter VII, Section 12 of the By-Laws be amended as follows:

The Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments shall consist of five members. Its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and alleviate mental illness.

In view of these recommendations I wish to withhold announcement of my appointments at this time, and ask permission of the House to make my committee appointments at the Tuesday morning session.

[Doctor Doege was authorized to announce these appointments at the third session on Tuesday.]

Report of Treasurer

REPORT OF DR. IRA R. SISK, TREASURER FOR THE YEAR ENDED DECEMBER 31, 1947

Cash on Deposit—First National Bank, January 1, 1947		$ 8,433.21
Revenues		
Membership Dues	$94,582.46	
1947 Exhibit Space Rentals	9,704.07	
Proceeds from Sale of Securities	9,436.86	
Panel Receipts—Wisconsin Plan	231.70	
Panel Receipts—Unemployment Compensation	40.00	
Roundtable Receipts	3,211.15	
Postgraduate Clinic Receipts	2,392.00	
Interest Received	1,357.28	
Principal Collected on Aetna Insurance Policy	1,004.40	
Total Revenues		121,959.92
Total		$130,393.13
Expenditures		
Constitutional Officers and Committees		
President	$ 500.00	
Council and Committees	5,020.81	
Books and Periodicals	373.90	
Auxiliary	100.00	
Secretary's Salary	9,500.00	
Secretary's Travel	1,884.79	
Group Total	$17,379.50	
Organization—Staff		
Assistant Secretary's Salary	$ 6,000.00	
Assistant Secretary's Travel	675.85	
Executive Assistant—Office	3,600.00	
Secretarial Staff	7,799.32	
Group Total	$18,075.17	
Administrative Expenses		
Accounting and Insurance	$ 2,585.62	
Social Security and Unemployment Compensation Taxes	569.68	
Office Rent	1,908.25	
Telephone and Telegraph	1,600.16	
Current Supplies and Light	2,012.20	
Postage and Printing	2,957.27	
Fixtures and Upkeep	720.99	
New Equipment	1,030.31	
Miscellaneous	1,128.56	
Group Insurance	251.10	
Group Total	$14,764.14	
Membership—Special Service		
Legal	$ 5,482.27	
Bulletins to Members	633.71	
Blue Book	750.00	
Group Total	$ 6,865.98	
Public Health—Normal Service		
Hygeia	$ 275.00	
Lay Publications	53.25	
Special Bulletins to Members	668.78	
Special Reports in the Journal	7.07	
Telephone and Telegraph	380.84	
Legislative Counsel	2,000.00	
Prepaid Medical Care and Veterans Medical Care	566.27	
Group Total	$ 3,951.21	
Public, Industrial and Rural Health, and Public Instruction		
Executive Assistant	$ 2,500.00	
Executive Assistant's Travel	892.19	
Staff Salaries and Travel	3,301.35	
Assistance, Press and Publicity	1,732.50	
Allocated Office Rent	705.00	
Press Releases	791.50	
Health Exhibits	631.13	
Radio Programs	2,878.33	
Industrial Panels of Physicians	1,714.30	
Group Total	$15,146.30	
Annual Meeting, Postgraduate Clinics, and Wisconsin Medical Journal		
Annual Meeting	$13,644.16	
Postgraduate Clinics	3,708.23	
Wisconsin Medical Journal	3,200.00	
Group Total	$20,552.39	
Other Expenditures		
Advance to Wisconsin Veterans Medical Service Agency	$ 5,000.00	
Advance to Wisconsin Physicians Service	10,000.00	
Deposit of Earnest Money—Paul E. Stark Company	5,000.00	
Group Total	$20,000.00	
Total Expenditures		$116,734.69
Cash on Deposit—First National Bank, December 31, 1947		$ 13,658.44

SECURITIES OWNED DECEMBER 31, 1947

Description	Interest Rate	Maturity Date	Face Value	Cost
U. S. Government				
U. S. Savings Defense, Series G	2½	6-1-53	$ 2,000.00	$ 2,000.00
U. S. Savings Defense, Series G	2½	6-1-54	6,000.00	6,000.00
U. S. War Savings, Series G	2½	9-1-54	3,000.00	3,000.00
U. S. War Savings, Series G	2½	6-1-55	5,000.00	5,000.00
U. S. War Savings, Series G	2½	1-1-56	8,000.00	8,000.00
U. S. War Savings, Series G	2½	8-1-56	5,000.00	5,000.00
U. S. Treasury	2½	9-15/67-72	3,000.00	3,000.00
U. S. Treasury	2½	12-15/67-72	10,000.00	10,000.00
Total Securities Owned, December 31, 1947			$42,000.00	$42,000.00

Report of Secretary

Secretary Crownhart: Mr. Speaker, one of the obligations of the Secretary is to file a statistical report (and a very brief one) for your information.

There are 3,359 doctors in Wisconsin, as far as we are able to ascertain, together with 22 who are in service, making a total of 3,381 physicians.

The State Medical Society has 81 members who reside outside of its territorial borders, and has a total of 3,039 members, of which 2,722 are classified as full dues-paying members.

At the time of the Council meetings it is my obligation, as Secretary, to file with the Council what is known as an interim report of the Secretary's office. Generally that report is concerned with certain statistical matters, the attendance of the Secretary at national meetings, requests for instructions, and the like. Yesterday, at the evening session of the Council, the Secretary departed from custom and filed a report of somewhat different character, and by instruction of the Council it is ordered transmitted to you today. Copies of it will be made available to each of you.

If a secretary of a highly organized society could be gifted with the potential power of self-division, it would be his greatest ambition to achieve just that. He would seek to become an alter ego of himself.

In the one person he would function to administer his organization's affairs, and in the other he would endeavor to properly appraise their value, their substance, and, above all, their contribution to the welfare of the meek who shall inherit the earth.

In this brief report your Secretary frankly attempts that self-division, and for the moment will try to persuade himself and convince you that he is capable of attaining a position that many of you may diagnose (and perhaps correctly) as a mild form of schizophrenia. Despite that possibility in the instant case, I take the risk, and even the greater one of providing this interim report in written form that you may document your findings.

At this point let me state a conclusion first, and clarify my purpose, by asserting that I am not concerned with the barnacles on medicine's ship of state, but with its course.

Certain matters in combination are becoming competitors of free enterprise for control of our economic and social philosophies. They should not be considered in the light of fear, but in light of cold facts. They in combination present a question—and the answer will determine whether the course remains one of preserving the freedom and independence of our current economic system, or of developing a new philosophy which only in light of foresight promises the greener pastures.

I, for myself, commit my personal judgment not to the status quo as that term is sometimes used, but to the continued growth and progress of what we have done, through freedom of enterprise, freedom of competition, and freedom from governmental serfdom. I see no greener pasture in any other course.

And in the ultimate determination of these and other fundamental questions hinges the future of your great profession and my great profession—but, more than that, the future of the people themselves.

I firmly believe that some of the major questions are these:

1. Medical Education.—Shall the education of the medical student be the sole responsibility of government? Or, shall this be continued as a combined effort—one of facilities furnished in part by government, one of teaching by those independent in thought and action, and one of ambition of the young person who has the encouragement and helping hand of his chosen profession?

2. Availability of Physicians.—Much has been said on this subject. No one in the medical profession wants anything but encouragement of adequate and reasonable distribution. Shall that movement go forward in response primarily to the economic law of supply and demand, or shall distribution of physicians be by governmental fiat and according to formula determined by calculating machines and the slide rule of impersonal technic?

3. Cost of Medical Care.—To those who need assistance, either by way of outright financial grant or by way of the provision of insurance as protection against catastrophic cost, medicine has provided and is continuously developing and extending proper mechanisms. But there looms on the horizon the possibility that these efforts can well become the Trojan Horse of governmental infiltration and control. Already one voluntary effort seeks governmental aid that it may provide certain benefits for those recipients of direct governmental relief, such as aid to the blind, aid to dependent children, and aid to the aged.

A recent report indicates that some are actively promoting the idea that the federal government should purchase certain of these lines of insurance protection—purchase them through a national agency of medicine's own making—purchase them at a national cost and with uniform benefits, and make them available as a beneficent bequest of the United States to the veterans of its wars.

It may be the right way of approach. If it is, it should be only if there is reasonable certainty that what the government buys will not become subject to a pattern of imposed bureaucratic specifications required for all. I know of no present method of protection against that eventuality. I would rather that government dictate by direction than by indirection. Under the former there are some possibilities of adequately demonstrating ineffectiveness, lack of training, and other dangers. Dictation by indirection, it seems to me, camouflages the real source of authority with the mantle of respectability of the medical profession.

4. Responsibility in Government Programs.—We in Wisconsin share pride in medicine's many con-

tributions to the accomplishments already gained by accepted government programs in the care of our unfortunates. But the mere appropriation of funds, the creation of a building with bricks and mortar, and the devising of a system, assures neither adherence to the initial medical standard nor its improvement. Medical care can be evaluated only by the trained physician; and that evaluation must be constant. This Society must support to the Nth degree the efforts of our many members who hold this problem as one that is acute and pressing. In medicine's tremendous responsibilities on many fronts let it abdicate none to the supervision of nonprofessional, though perhaps well-intentioned, individuals.

Finally, may your Secretary conclude what may strike some of you as a report unusually brief considering its source. May he conclude by saying that these four fields he has mentioned constitute merely a fragment of the whole. They were chosen in part because they seem the most pressing, and in part because they seem illustrative of the whole scheme of things.

Your Secretary reports intense efforts and studies by the various committees of the Society in all these matters. He does express the finding that there are some of us, himself included, who fear they sniff a growing taint—or perhaps odor would be the better word—of only self-concern and limited horizons on the part of some whose interest thus far has been more aloof than real.

There lies your profession's greatest responsibility. The leadership is yours.

Your Secretary bespeaks your even greater efforts in developing the actual and potential medical statesmanship of this Society — geographically within the state, by specialty and age groups within the profession—and by cooperation with the laity and the press in such of their efforts as may be viewed as constructive and wholesome.

In addition to the necrology report submitted to you through the Council, it is the Secretary's duty to report the death since then of Dr. Carl Vogel, of Elroy; Dr. F. M. Bair, of Cuba City; and Dr. L. F. Ruschhaupt, of Milwaukee.

[The necrology report was published in the September issue of *The Wisconsin Medical Journal.* p. 911.]

Presentation of Distinguished Guests

The Speaker presented the following guests, who spoke briefly before the House: Mr. Philip S. Habermann, executive secretary of the Wisconsin State Bar Association Mr. R. R. Rosell, secretary of the Minnesota State Medical Association; Dr. A. E. Cardle, president of the Minnesota State Medical Association; Dr. Frank J. Elias, chairman of the council of the Minnesota State Medical Association; Dr. E. B. Howard, assistant secretary of the American Medical Association; and Dr. George F. Lull, secretary and general manager of the American Medical Association.

Excerpts from Report of Subcommittee on Cooperation of the Council on Medical Service and Public Relations

Dr. L. O. Simenstad (Osceola): I think most of you know what a cooperative is, although you have had only a little knowledge of them. You know what consumer cooperatives are and what producer cooperatives are, and all that sort of thing, so before going into this I think perhaps you should have a little information about the economics of cooperatives—a very, very elementary talk.

I don't think it makes much difference whether you are in business or whether you are in medicine —I think the medical doctor, famous though he was and full of tradition, has certainly gone by the boards.

There is nothing so constant as change. That is one thing we sometimes don't stop to think about. We look around and see long dresses and realize that they are the "new look."

The public is interested in that sort of medicine and you might as well make up your minds to it. As a doctor, I might say we have been scientifically-minded. I think most of us read, most of us do scientific medicine but we have always been telling patients what to do. We tell someone that he has to do thus-and-so or he won't get along so well. We don't like to have anyone tell us that we are giving wrong advice; neither do we want the cooperatives or the government or anyone else to tell us what what we are doing is wrong. We must think ahead, and we have to be very broadminded in thinking of this whole subject of economic medicine.

As you have been told, this cooperative matter has been brewing for a long time. Several years ago there was a meeting at Two Harbors, and Mr. Rosell and Mr. Crownhart were there, as observers, and all of us thought it was no good and it would never amount to much. This thing has been progressing, however, although you may not think so.

They have an organization now under Jerry Voorhes. He used to be a congressman from Chicago. Four states are set up under an office in St. Paul. They have a small hospital project going up in Milltown, Polk County, which seems to be the center of that sort of thing. It is just another outcropping of this whole economic system. I believe we as a group are very, very wrong if we sit back and, with sarcasm, talk against it and say "It can't happen to us" and let things go on. As these gentlemen have told you, we should be the leaders in all these projects. That is the only way we can ever get ahead.

In Polk County they are spending $12,000. They have been given that much money to start this cooperative hospital. What is going to happen when this thing gets going? Nobody knows, and I don't want to be an alarmist—I am far from one—and I think all these problems that we rant and worry about don't amount to very much, anyway. If we use our heads and get along with each other, and

think these things out and give the leadership to them that we should give, then the problems won't be so serious.

I believe the first thing we should recognize is that things do change, that we can't sit by, like the British Medical Society, who says, "They can't do that to us, and we aren't going to take it, and we just won't practice medicine." For a while they pushed the matter away. But eventually it is going to engulf you. You have to cooperate with people; you have to get along with the leaders, and you have to give some constructive leadership in this whole problem of medical distribution.

Perhaps we have been a little slow, but I think we can solve some of these problems very well. I believe we should have insurance plans that take care of all people, whether one person or five people or a thousand. That should be worked out some way or other, either with the physicians or the insurance companies, or by some other means.

Fear is one of the things that keeps medicine from moving ahead. We fear the competitors; we fear our doctors; we fear the nurses; we fear everything. There isn't anything to fear. It should not be true at all; certainly not in medicine. We should be able to sit down with Milwaukee County and straighten out our differences. If we can't straighten them out we won't get anywhere, so perhaps the best thing to do is to get together with some sort of program and see that matters are straightened out properly.

Last evening someone gave me a clipping which came from the Milwaukee Journal of Thursday, September 30. It says: "Campaign to Start for Health Center." The article is dated from Kenosha, Wisconsin: "A campaign to raise $125,000 among the workers of Kenosha for the building of a health center will be started Monday by the Community Health Center Cooperative, Inc. A $10,000 loan to start the drive was made to the newly organized health group by Local 72, UAW-CIO, it was announced Thursday. A $500 loan was made by the A. F. of L. Milk Drivers' Local 511.

"The cost of individual memberships in the health center is $25 in addition to the following monthly dues: Single persons, $3. Married couples, $5. First dependent, $1. Second and third dependents, 50 cents each. The rates do not include hospitalization, but will make available complete medical and dental care on a prepaid basis. Drugs, medical and dental supplies and appliances will be sold at reduced costs to members. If the membership drive succeeds, a modern clinic will be built and equipped here."

That is in Kenosha. Some of you boys probably are from Kenosha. You might say that isn't true. Maybe not, but if it isn't true in Kenosha it is true up in Polk County, in Duluth, and is true in various other places.

You are not going to control these people like you control your senators; you write the senators and representatives and put pressure on them. Gentlemen, you can't pressure people into doing what you want them to do any more than anyone can pressure you into doing what they want you to do. It is a much bigger problem than that.

I just want to tell you that it is here; it is part of the whole economic system.

Whatever you do, don't get all stirred up and worried, and don't say "You can't do this to me," because as soon as you say that somebody is going to do it.

Excerpts from the Report By State Health Officer

Dr. Carl N. Neupert: The privilege I have of reporting to the governing body of the State Medical Society is much appreciated.

Today I intend to appraise some of our joint problems, and to point out weaknesses, strengths, and needs.

Let me remind you that your State Board of Health is charged by the statute with the responsibility (a broad one) for the life and health of the citizens of the state. This Society had a part in getting that provision into the statute books, and has supported the Board since its inception in 1876. Over the years that Board has laid up a record of steady progress in public health. It has remained consistently in the field of prevention. Unfortunately, the program to achieve that progress has met with resistance on the part of some of the county medical societies, so the going was not easy for the Board always.

Take the introduction of the miniature x-ray tuberculosis survey program, for example: It is now very well accepted, but for a while the general public and industry were ahead of the doctors in some of the communities in a recognition of its potential benefits in reducing tuberculosis.

Or, take immunization against communicable diseases: Agreed, it would be better to have every physician practicing public health in his office doing immunization of his own patients, beginning soon after delivery, but until we fully meet that responsibility in our offices we can't let a large percentage of our children grow up in a community unprotected. An epidemic due to a disease for which we have a proven preventive is unthinkable, and would really arouse folks; or, too, some county societies have disregarded the social importance of over-all community protective in their determination to take a stand that to them is proper but which may not be entirely in the public interest.

I understand that there is opposition to the program of the State Laboratory of Hygiene, as though it were interfering with laboratory practice. Gentlemen, no state laboratory has a clearer record of sticking to preventive phases of work than our own State Laboratory of Hygiene. I could go into the matter of the comparative studies in obstetrics entirely for purposes of bringing the obstetric picture to you. There is absolutely no interference with the practice of medicine in any way. Information was extended so that you could make the improvements

in your own way. It is our function to make those studies.

I mention a few of these problems particularly to arouse you. Your State Board of Health has steadfastly adhered to a program of preventive public health. By many authorities in the field we are held now as old-fashioned. They hold that preventive and curative medicine cannot be separated, and that the medical care by official public health agencies is unavoidable. I have listened to a representative of the American Academy of Pediatrics who expressed that view. We on the Board aim at the helping of people to help themselves and doing things for them only if they can't do them for themselves. We feel that if we can get a good job of preventive public health done there won't be a need for untried experiments in providing medical care by governmental agencies.

Certainly preventive public health should be given a good trial first. Your officers and committees have seen this whole picture more clearly than many local groups because they have studied it and have learned the facts. The support and leadership of the State Medical Society in legislature has been and will be indispensable. You have an excellent Board. I need not remind you that our president is the Chairman of your Council, and that our past president is now your Speaker. These men have given the matter study and are not hanging back.

What needs doing? First, in general a study by county medical societies of the trends in public health and what is going on in the country, not just blind opposition to anything that has a Washington or a Madison label. Opposition to every suggestion is a negative attitude that can only leave us behind the field.

More specifically, put your solid suport behind the setting up of county health departments in Wisconsin. Without your active support the enabling act would never have been passed. Now, study what a county health department stands for. Push this development of locally-governed preventive health. Incidentally, it is the best answer in Wisconsin to the proposal that Wisconsin or the nation adopt compulsory health insurance.

County health departments cost money. A State Aid bill is being prepared for introduction into the legislature. Under its provisions funds will be available for the state somewhat as aid for county nurses is now operating. Local tax sources are being used up to the limit as far as property tax is involved. County health departments pay dividends in saving cost of health neglect so that they are really an investment. It is a wise expenditure of state funds to get public health services for the rest of the state, especially the rural areas, that are comparable to those in the eleven largest cities now having such full-time health departments.

Then, there is a need for a new State Laboratory of Hygiene building on the campus. It is not just desirable—it is a necessity if the preventive health phases of public health are to be met with other than 1928 space and equipment facilities.

We are blocked in doing a real job even on water analysis for schools and farms. We are trying to find out how brucellosis is spread from animal to man. We need to tie up the spread of the diseases of the laboratory worker in gastrointestinal episodes and food poisonings that are going on. There is a so-called intestinal flu that makes a lot of people sick for one or two weeks which we can't investigate for lack of laboratory facilities.

I hope this House of Delegates will take a stand so that you as individual physicians can carry to your patients and the legislature facts about this need, so when the bill comes up the issues will be understood.

I hope this House goes on record for state aid for county health departments. Without that aid the development may be very slow.

In conclusion, a re-emphasis of this plea: Get solidly behind public health as you have it in Wisconsin. Get better informed about it. As a state organization you are fine; as individual societies in some instances you withhold that support. You have a splendid State Board of Health, with a fine trained medical staff. Help it along. It is in your interest as well as in the public interest.

Referral of Committee Reports

The reports of committees and proposed resolutions were referred to the proper reference committees, and the recommendations of the following committes were reviewed: Committee on Cancer, Committee on Industrial Health, Committee on Hearing Defects, Committee on Maternal and Child Welfare, Committee on Mental Hygiene, Committee on Goiter, Committee on Hospital Relations, Committee on Rural Health and Accidents, Advisory Committee on Care of Crippled Children, Council on Scientific Work, Committee on Tuberculosis and Chest Diseases, Committee on Health and Public Instruction, Council on Medical Service and Public Relations, Committee on Coordination of Medical Services, Special Committee to Study Committee Structure, Committee on Grievances, and Committee on Public Policy. The attention of the House was also directed to the report of Wisconsin Physicians Service.

Greetings Sent to Doctor Malloy

It was moved by Dr. E. C. Cary that greetings and wishes for a speedy recovery be sent to Dr. T. E. Malloy of Random Lake, a member who was to receive the Fifty Year Club pin, who was in the hospital at Sheboygan. The motion was severally seconded and passed unanimously.

Committee on Nominations Approved

The following list of physicians was submitted to serve as the Committee on Nominations:

District	Nominee
1	W. H. Costello, Beaver Dam
2	Carl Schaefer, Racine
3	L. V. Littig, Madison
4	George Parke, Sr., Viola
5	E. C. Cary, Reedsville
6	B. J. Hughes, Winnebago
7	R. L. MacCornack, Whitehall
8	H. W. Haasl, Peshtigo
9	M. L. Jones, Wausau
10	S. E. Williams, Chippewa Falls
11	Charles W. Giesen, Superior
12	E. L. Bernhart, Milwaukee
13	C. E. Zellmer, Antigo

Acceptance of the list was moved by Dr. J. W. Fons, seconded by Dr. G. W. Carlson, and carried unanimously.

Adjournment

The first session adjourned at 5 p.m.

SECOND SESSION

October 4, 1948

The second session of the House of Delegates of the State Medical Society of Wisconsin convened at 6:45 p.m., Dr. Gunnar Gundersen, Speaker of the House, presiding.

Introduction of Distinguished Guests

The Speaker of the House presented Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, and Dr. James E. Buckley, president-elect of the Oregon State Medical Society, to the House.

Report of Committee on Credentials

The Committee on Credentials verified the registration of forty-four delegates and seven alternate delegates entitled to vote at the Second Session. Five alternate delegates and two Councilors had also registered. On motion of Doctor Carlson, seconded by Doctor Cary, the report was unanimously accepted.

Report of Reference Committee on Reports of Officers

The first committee reporting consisted of Drs. M. C. Borman, Milwaukee, chairman; E. C. Cary, Reedsville; R. S. Hirsch, Viroqua; and L. O. Simenstad, Osceola.

Doctor Borman, speaking for the committee, reported that acceptance of the President's address was urged, with an expression of gratitude from the State Medical Society through the House of Delegates. The committee pointed out that Doctor Stovall's outline of the responsibilities of the profession in developing its program in this period of economic change was ably stated.

The committee was of the opinion that the comments offered by Doctor Doege in his address should receive the continued consideration of the members of the House. It was recommended that the suggestions made by President-Elect Doege to amend the By-Laws be accepted. Amendment of Chapter VII, Section 19, relating to the Committee on Hearing Defects, was moved by Doctor Borman, seconded by Dr. E. L. Bernhart, and carried unanimously. Doctor Borman also moved that, in accordance with Doctor Doege's suggestion, the Committee on Medical Education and Hospitals include the deans of the two medical schools. The motion was seconded by Dr. G. W. Carlson and carried unanimously. Amendment of Section 12, Chapter VII, relating to the Committee on Mental Hygiene and Institutional Care, was moved by Doctor Borman, seconded by Dr. C. O. Schaefer, and carried unanimously.

The next portion of the report pointed out that the committee was impressed with the care given by Speaker Gundersen in presenting his report and called attention to his recommendation that a special committee be appointed to reappraise the Wisconsin General Hospital Law. It was recommended that the House advise the incoming President to constitute such a Committee charged with the duty expressed by the Speaker.

Emphasizing that the Society owed a debt of gratitude to Doctor Sisk for serving as treasurer for more than a decade, the committee recommended acceptance of the Treasurer's report.

The report of the Secretary was recommended for acceptance.

Because of its importance, the report of the Committee on Grievances was presented in full as follows:

The activity of this committee has been increased due to the added responsibilities given by the House of Delegates last year. By way of commenting upon the general functions, it is reported that several matters have been brought to the Committee's attention with satisfactory disposition. Your committee further reports that, due to the resignation of one of its members, this report is submitted only by Drs. J. W. Prentice of Ashland and E. W. Mason of Milwaukee.

The Committee on Grievances of the State Medical Society of Wisconsin, by direction of the President, has undertaken to examine the situation relative to expert medical testimony. In this connection it has met with a committee of the State Bar Association which finds itself in accord with the substance of this report.

On some occasions, and in connection with specific instances, claims have been made that such testimony was either inaccurate, sometimes submitted by those not properly qualified, or, and infrequently, that it was biased to the extent of being untrue.

The committee does not here analyze those situations, nor justify the complaints. If there are such occurrences, the committee is satisfied that they are infrequent, and perhaps involve so many factors that it is impossible to attach any blame upon one particular individual as separate from others involved in the hearing.

Nevertheless, the committee believes that the fact such claims are made is sufficient cause to consider the problem carefully. It has therefore given consideration to the program instituted in Minnesota, and with variations in Illinois, as intended to assure the presentation of proper testimony, and avoid substance to any accusation to the contrary.

With the approval of the House of Delegates, your committee proposes to install the essence of the Minnesota plan in Wisconsin, and to function in the following manner: In any proceeding where

those licensed to practice medicine and surgery are qualified as expert witnesses, and where the judge, presiding official, any of the participating attorneys, or another physician expresses in writing, for transmittal to the committee, that an expert has falsified in testimony, or demonstrated incompetence, the committee will assume jurisdiction of the matter.

In such event the name of the case will be secured, and at the expense of the Society a certified copy of the testimony obtained, together with such other material as is pertinent. The name of the reporting party will be kept confidential.

The committee will review the matter generally, and where indicated will call in other members of the Society who are particularly qualified in that particular field, for their advice and assistance.

After study it may, as in Minnesota, take action in the following respect:

1. It may determine that the witness properly testified.
2. It may determine that the witness should be censured or warned, in which case he will be called before the committee.
3. It may file with appropriate state agencies recommendations for further investigation.
4. It may determine that the problem in essence involves attorneys, in which case it will refer the matter to the appropriate body of the State Bar Association.

In summary, the committee is willing to assume a general responsibility in the field, recognizing that any specific ethical problem must be routed through appropriate bodies within the State Medical Society. The committee doubts that the problem as asserted to exist is of any great consequence, but does believe that the very fact that such assertions are sometimes made indicates the need for handling any complaints. The committee believes that any cause of action will be the exception rather than the rule, and that the real problem lies in the present freedom of assertion rather than in its substance.

Nevertheless, justice is not blindfolded in Wisconsin. To the extent the State Medical Society may assist in preserving its impartiality, it is a privilege as well as a civic duty.

On motion of Doctor Borman, seconded by Doctor Stewart, the House voted unanimously to undertake this responsibility along the lines followed in Minnesota.

The adoption of the reports of the Committee on Venereal Diseases, Committee on Open Panels, Committee on Military Medical Service, and Committee on Wisconsin Veterans Medical Service Agency was also recommended by the committee. The following motion, relative to the Committee on Military Medical Service, was made by Doctor Borman:

It is hereby moved that the President of the State Medical Society and members of the Committee on Military Medical Service are hereby directed to meet with the Governor of Wisconsin and recommend that he establish a State-wide Committee for Civil Defense and Disaster Planning, the medical aspects of which would be coordinated through a six-man State Medical Society committee, two members of which shall be the state surgeon of the National Guard and the state health officer.

The motion was seconded by Doctor Drew and carried unanimously.

Doctor Borman also introduced the following motion of the committee:

That the House of Delegates request that each county medical society set up a Committee on Military and Disaster Medical Service to work with the State Medical Society committee in the establishment and administration of local disaster relief programs.

The motion, seconded by Doctor Drew, was carried unanimously.

The suggestion of the Council to amend Chapter VIII, Section I, relative to life membership, was made a motion by Doctor Borman, seconded by Doctor Drew, and carried unanimously.

Because of the controversial nature of the issue, the recommendation of the Council to adopt the resolution of the House of Delegates of the American Medical Association accepting the obligation to pay the state and national dues of its auxiliary members was referred back to the respective county medical societies for action by motion of Doctor Borman, seconded by Doctor Stewart, carried unanimously.

The Reference Committee on Reports of Officers recommended that one member be held over for chairman of the committee for the following year. Adoption of the procedure was moved by Doctor Borman, seconded by Doctor Bernhart, and carried unanimously.

The report of the Reference Committee on Reports of Officers was accepted section by section by the House, and, on motion of the chairman, seconded by Doctor Carlson, the entire report was accepted unanimously.

Reference Committee on Reports of Standing Committees

The next reference committee to report was that on Reports of Standing Committees, composed of Drs. L. R. Cole, Madison, chairman; C. F. Midelfort, La Crosse; H. W. Pohle, Milwaukee; and W. S. Bump, Rhinelander.

Doctor Cole, chairman, stated that the report of the Committee on Cancer had been studied and recommended for acceptance. On motion of the chairman, seconded by Doctor Borman, the House unanimously approved its acceptance.

The committee recommended that the report of the Council on Medical Service and Public Relations and the subcommittees of that council—that on the Wisconsin Interscholastic Athletic Association and that on Nursing—be approved. Moved by Doctor Cole and seconded by Doctor Stuessy, the report was unanimously accepted by the House.

Requests had been made for expansion of industrial health clinics and a study of credit ratings for small groups by the Committee on Industrial Health. On motion of Chairman Cole, seconded by Doctor Bernhart, the report of this committee was unanimously accepted by the House.

It was pointed out that the Committee on Hearing Defects was attempting to initiate and promote hearing programs in certain of the Milwaukee Public Schools, following the pattern of those conducted in a number of the schools in Washington, Polk, and Ozaukee counties. Doctor Cole moved acceptance of the report; it was seconded by Doctor Baumann, and unanimously carried.

Attention was directed to certain problems in connection with premature infants in the report by the Committee on Maternal and Child Welfare. Consultation with senior staff members was also advised by this committee when cesarean section appeared to be indicated. The reference committee recommended acceptance of the report. Made a motion by the chairman and seconded by Doctor Baumann, approval of the House was unanimous.

The report of the Committee on Mental Hygiene and Institutional Care was recommended for acceptance. In addition, the reference committee suggested the following statement as an addition to the third recommendation by that committee: "That this problem of the sexual psychopath be referred to the Youth Service Commission and the Department of Public Welfare." The chairman moved acceptance of the report with the addition of this suggestion, seconded by Doctor Bernhart, and carried unanimously.

On recommendation of the reference committee, Doctor Cole moved acceptance of the report by the Committee on Goiter, seconded by Doctor Baumann, and carried unanimously.

The report of the Committee on Hospital Relations, which had sponsored a series of regional conferences in 1948, recommended that similar meetings be held throughout the state during the coming year. Acceptance of the report was moved by the chairman, seconded by Doctor Drew, and carried unanimously.

The Committee on Rural Health and Accident Prevention in its report asked for an initial State Rural Health Conference, to be sponsored by the State Medical Society through the Committee on Rural Health and Accident Prevention, with participation by farm organizations for possible solutions of problems arising among the rural populations. Establishment of contact with 4–H Clubs and financial assistance for the development of health projects among rural young people were also urged. Acceptance of the report was moved by Doctor Cole, seconded by Doctor Stewart, and carried unanimously.

The report of the Advisory Committee on Care of Crippled Children directed attention to the efforts and valuable services of Mr. Frank Powell, director of the Bureau of Handicapped Children. Doctor Cole moved acceptance of the report; it was seconded by Doctor Drew and carried unanimously.

The committee recommended acceptance of the report of the Council on Scientific Work, expressing the hope stated by the chairman of that group that a greater interest in the scientific aspects of medicine may be fostered. A motion to accept the report was made by Doctor Cole, seconded by Dr. R. S. Hirsch, and carried unanimously.

The Committee on Tuberculosis and Chest Diseases in its report expressed disapproval of the expansion of state services except in cases in which local facilities are inadequate for diagnostic purposes. It further stated that the State Board of Health should be available for consultation service and concluded that routine x-ray examinations of the chest are of value in tuberculosis detection. No agreement was reached on charges for this procedure. Further action by the committee was deemed necessary.

The program of public health education and instruction meeting with a high degree of acceptance by the public and serving an exceedingly valuable purpose, acceptance of the report of the Committee on Health and Public Instruction was moved by Doctor Cole, seconded by Dr. M. Q. Howard, and carried unanimously.

The report of the Committee on Coordination of Medical Service, which acts as a link between the University of Wisconsin Medical School, the State of Wisconsin General Hospital, and the Wisconsin physicians, was recommended for acceptance. The motion, made by the chairman, was seconded by Doctor Drew, and carried unanimously.

It was the opinion of the reference committee that reevaluation of the functions of the committees of the State Medical Society was necessary, with organization of new committees or amalgamation of old committees. As it was felt that certain committees were obsolete and the work of others overlapping, the committee recommended that the report of the Special Committee of the House to Study Committee Structure be referred back to that committee. The motion for this action, made by Doctor Cole, was seconded by Doctor Baumann and carried unanimously.

Doctor Cole then introduced the following resolution submitted by Dr. W. C. Stewart:

Whereas, the medical profession is not unmindful of the necessity of giving adequate and necessary care to the sick and injured, and

Whereas, the sole responsibility of providing a family physician for an emergency does not rest entirely with the medical profession, and

Whereas, it becomes the duty of every physician to provide medical service for his patients even during his absence or illness, and

Whereas, the layman through a public relations program of education should be schooled in the advisability and necessity of having a family physician on whom he can and should depend for medical service even in an emergency; now, therefore, be it

Resolved: That the House of Delegates recommend and urge a program of lay education to each county medical society through its public relations committee, wherein each family or individual is requested to select and maintain a family physician; and be it further

Resolved: That an adequate panel of physicians be made available daily in each community for emergency medical service.

On recommendation of the reference committee, moved by Doctor Cole, seconded by Doctor Howard and carried unanimously, the resolution was referred back to the Council on Medical Service and Public Relations.

The following resolution originated with the reference committee:

Whereas, the State Medical Society of Wisconsin has been charged with the responsibility of promoting health education of an acceptable quality for public use, and

Whereas, it is earnestly attempting to accomplish its purpose through the means at its disposal, and

Whereas, radio has offered an exceptional means for the accomplishment of its purposes, and

Whereas, twenty-three of the radio stations in Wisconsin and two stations in Michigan have offered the facilities of their stations for the broadcast of the weekly programs of the MARCH OF MEDICINE, as a public service; be it

Resolved: That the State Medical Society of Wisconsin extend the acknowledgement of its deep debt of gratitude for this public-spirited attitude and cooperation of these listed stations:

WHIY, Appleton	**WMAM, Marinette**
WATW, Ashland	**WDLB, Marshfield**
WBEL, Beloit	**WIGM, Medford**
WEAU, Eau Claire	**WEMP, Milwaukee**
KFIZ, Fond du Lac	**WNAM, Neenah**
WTAQ, Green Bay	**WOSH, Oshkosh**
WIKB, Iron Mountain	**WOBT, Rhinelander**
WJMS, Ironwood	**WJMC, Rice Lake**
WLIP, Kenosha	**WHBL, Sheboygan**
KWHH, La Crosse	**WLBL, Stevens Point**
WIBA, Madison	**WSIR, Superior**
WOMT, Manitowoc	**WAUX, Waukesha**
WLDY, Ladysmith	

and that the Secretary of the State Medical Society communicate these sentiments as approved by the House of Delegates meeting in its 107th annual session in Milwaukee, Wisconsin, on this 4th day of October, 1948.

On motion of Doctor Cole, seconded by Doctor Bernhart, the House unanimously voted to accept the report of this reference committee.

Report of Reference Committee on Resolutions

The final reference committee to report was the Reference Committee on Resolutions, composed of Dr. L. A. Copps, Marshfield, chairman; R. P. Montgomery, Milwaukee; H. A. Kasten, Beloit; A. J. McCarey, Green Bay; and J. S. Supernaw, Madison.

Doctor Copps, chairman, introduced a resolution proposed by Dr. C. F. Midelfort recommending the appointment by the Speaker of the House of a Special Committee on Public Health. The committee, composed of five members, would confer with government and private agencies and study the problems involved. A motion made by Doctor Copps to adopt this resolution was seconded by Doctor Stuessy and carried unanimously.

Establishment of a Scientific Section on Pediatrics was proposed, with such Section having all powers and obligations of sections as contained in Chapter XII of the By-Laws, including delegate representation. Adoption was moved by the chairman, seconded by Doctor Drew, and carried unanimously.

The committee suggested disapproval of the resolution recommending preparation of mimeographed abstracts of the proceedings of the House and asked delegates to note the detailed minutes in the December issue of The *Journal*. The House moved adoption of the suggestion.

Commendation was made to each member of the directing board of Wisconsin Physicians Service, and the House, on motion of Doctor Copps, seconded by Doctor Howard, moved acceptance of the report of this group.

The changing of the name of the Committee on Extension of Insurance to the Wisconsin Plan Committee was moved by Chairman Copps, seconded by Dr. George Parke, Sr., and carried unanimously. Members of the committee were commended for their work.

Following commendation of the members of the Committee on Public Policy, adoption of the resolution concerning Wisconsin Physicians Service, introduced by Dr. L. O. Simenstad, was recommended, with revisions as follow:

"Be it therefore

Resolved: That the Directing Board of Wisconsin Physicians Service be urged to make an immediate study of the feasibility, cost, and contract provisions of making coverage available to individuals and non-group families, and to report that study to the Council for further consideration and action at the earliest practical date."

Adoption of the resolution was moved by Doctor Copps, seconded by Doctor Cole, and carried unanimously.

The report of the Council on Medical Service of the American Medical Association relative to the organization of a national insurance company and a national amalgamated association of Blue Shield and Blue Cross was distributed to the members. Dr. James Buckley of Portland, Oregon, was asked to discuss the actions of this group and of the Board of Trustees of the American Medical Association on this matter.

Dr. James Buckley: About ten days ago our Blue Cross plan in Oregon received a copy of this proposal for the amalgamation of the higher echelons of Blue Cross and Blue Shield into two separate corporations for the purpose of getting over the country as a whole plans which will be more acceptable to the labor leaders of the country, who have been in consultation with General Hawley.

Considerable pressure has been exerted, apparently, by a number of these groups, to get an overall plan which will supersede all the state plans of the Blue Cross and various other prepaid plans that are in vogue over the country.

In Oregon we have had plans of this type running since about 1912, and we have been in continuous difficulty with them since that time. We feel, particularly in Oregon and Washington, where these have been going for many years, that many of the people in other states have not had the benefit of some of the difficulties we have had. I want to make very definite that we do believe in prepayment plans, but we do believe they certainly should be watched very carefully, and a national plan of this kind has such wide implications that I believe it should be considered very thoroughly.

This thing was up at the Los Angeles meeting of Blue Shield, and there was considerable opposition to it at that time. In spite of that opposition, almost the same plan has come out now and has been approved by the two commissions, and was submitted to the Council on Medical Service last Thursday.

This plan is set up now to be approved by the Blue Cross and Blue Shield groups in a meeting at French Lick Springs, Indiana, on October 25. That is before the House of Delegates meeting of the American Medical Association, and we feel it is highly imperative that the medical societies over the country know something of its implications, and

register their disapproval through their Blue Cross plans and through societies as such.

The proposal that was brought out was not sent to the state societies, was not sent to the Trustees, but was simply brought in an informal manner to the Blue Cross–Blue Shield plans, and also the discussion was carried out last Thursday. This has already had the disapproval of the Council on Medical Service. However, this does not prevent the Blue Cross–Blue Shield organizations from going ahead with this plan, even though they do not have the approval of the Council on Medical Service. In order to stop this general insurance plan it is necessary that it be brought forcibly to the attention of your plans here, if you do disapprove of this sort of plan.

Briefly, it calls for the setting up of two corporations, one a service company which would receive contributions from various Blue Cross plans. Funds of that corporation can be reinvested in the second corporation, known as the Health Service Corporation, which would set up a company to cover all states in writing riders on the present Blue Cross plan to give a uniform plan over the country.

This has very manifest difficulties from the standpoint of having a number of different contracts in different states, with different riders, and it would require the company to put up funds and become licensed in every state in the Union. It would require a very difficult and devious type of bookkeeping to see how much responsibility rested with the Blue Cross plan in another state and how much with the parent corporation.

It looks to those of us who have studied it as though we will be setting up a federal plan by ourselves which can be very easily taken home by the federal government. With the present status of acceptance of prepaid care in this country, it is quite obvious that no plan will suit all the people in this profession over the country, and it is our belief that the public relations of our profession as a whole will be very definitely lowered by the manifest difficulties that will be brought out when this is attempted to be enforced in all states.

I might call your attention to the fact that in the proposal of this corporation they say these riders will be put in, and they use the words "unwilling or unable" concerning the local plans. I will read you about ten lines from this:

"Beyond acting as an enrolling and billing agent, this corporation proposes to write excess coverage in areas where local plans are unable or unwilling to provide all the benefits demanded by particular national accounts. Each opportunity will be given to local plans to extend their own benefits to meet such requirements."

However, if the local plans do not wish to do that, and are unable to do so or are unwilling, as expressed here, the parent corporation on a national level will write on those riders.

The final line of that same paragraph says, "Service guarantees on the excess coverage will depend entirely on the willingness of local hospitals and physicians to accept the indemnity schedule for such benefits as full payment."

We believe this plan at this time would lead to such serious disruption and such serious differences of opinion among the profession of the country that it would be highly unfeasible to adopt any national insurance plan at this time.

* * *

The following resolution was introduced, and after some discussion about delaying action until after the meeting at French Lick Springs, it was felt that the House should go on record as being opposed to any movement toward socialization of medicine. Adoption of the resolution was moved by Doctor Copps, seconded by Doctor Stuessy, and unanimously voted by the House.

Whereas, the Council on Medical Service of the American Medical Association has seen fit to study in detail the proposed formation by Associated Medical Care Plans and Blue Cross of an insurance company, and

Whereas, the far-reaching potentialities of this proposal are of importance to organized medicine in Wisconsin, as well as all over the rest of the United States, and

Whereas, the Council on Medical Service has recommended to the Board of Trustees and the House of Delegates of the American Medical Association that at this time the Council does not approve the formation of a national health insurance company under the auspices or direction of Blue Cross and Blue Shield, and

Whereas, the recommendation has been approved by the Board of Trustees and will be introduced at the Interim Meeting of the House of Delegates of the American Medical Association; therefore, be it

Resolved: That the House of Delegates of the State Medical Society of Wisconsin go on record as approving the action of the Council on Medical Service of the American Medical Asssociation.

In light of the fact that (1) there is an inflationary trend in the country, (2) the Society has purchased a new home, (3) the Society operates voluminously in many fields, (4) members of the staff are in constant touch with national developments relating to medicine, and (5) the Society serves many professional and scientific needs of its members, the committee recommended increasing the dues to $50 per year. Moved by Doctor Copps, the recommendation was severally seconded and carried unanimously. [The complete text of this recommendation is found on page 1188 of this issue.]

Recess of the Second Session

The meeting recessed at 7:45 Monday evening and reconvened at 9:25 Tuesday morning, Dr. Gunnar Gundersen, Speaker of the House presiding.

Supplementary Report of Committee on Credentials

Since the last report, 15 delegates and 5 alternate delegates had registered and were entitled to vote. In addition, 5 alternate delegates and 2 Councilors had registered. A motion for acceptance of the supplementary report, presented by Doctor Carlson, was carried.

Supplementary Report of Reference Committee on Resolutions

Former resolutions concerning Milwaukee Surgical Care were replaced by the committee's own resolution, reading as follows:

Whereas, numerous attempts to consolidate Wisconsin Physicians Service and Milwaukee Surgical Care into one Statewide plan have failed, and

Whereas, a final attempt made by this Committee yesterday afternoon also failed, and

Whereas, in October 1946 this House of Delegates withdrew its approval of Milwaukee Surgical Care as of November 30, 1946; be it therefore

Resolved: That the State Medical Society of Wisconsin notify the Insurance Commissioner of Wisconsin that Milwaukee Surgical Care is no longer operating in a manner approved by the State Medical Society of Wisconsin; and be it further

Resolved: That the State Medical Society of Wisconsin expresses willingness to receive from the Medical Society of Milwaukee County overtures relative to the consolidation of the two plans, which may be transmitted to the Council of the State Medical Society of Wisconsin at any time.

Acceptance of the resolution was moved by Doctor Copps, seconded by Dr. O. W. Saunders, and, after discussion, carried unanimously.

On recommendation of the committee, accepted by the House, the officers and councilors of the Society were voted a rising vote of thanks.

Adoption of the entire report of the Reference Committee on Resolutions was moved by Doctor Copps, seconded by Doctor Cole, and unanimously approved by the House.

Resolution to Amend the Constitution

The following resolution to amend the constitution was introduced by Dr. J. S. Supernaw:

Whereas, the Constitution of this Society provides that the House of Delegates shall divide the State into such Councilor Districts as will promote the best interests of the profession, and

Whereas, the membership of this Society, involving some 3,000 members, is under the jurisdiction of a body twice the number that directs the activities of the American Medical Association, which totals a membership of nearly forty times that of the Medical Society of the State of Wisconsin, and

Whereas, the Board of Trustees of this Society is virtually one-half the number deemed necessary by the electors of this State to represent them in the Senate of this State, and is approximately one-sixth the number of United States Senators to represent a nation of 140 million people, and

Whereas, under the present system, factionalism and sectionalism is promoted rather than prevented; be it

Resolved: That the Constitution and By-Laws of the Medical Society of the State of Wisconsin be amended as follows:

1. Article VI of the Constitution: To replace "nine" in the last sentence to "seven" so it shall read "Seven of its members shall constitute a quorum."

2. Article IX of the Constitution, Section 1: To replace "thirteen" to "ten" so it shall read, "The officers of this Society shall be a President, a President-elect, a Secretary, a Treasurer, Councilors from ten districts, and a Speaker and Vice Speaker of the House of Delegates."

3. Article IX, Section 2 of the Constitution: To strike out the word "thirteen" and replace it with the word "ten" and end this Section with the word "districts," so it shall read, "The officers, except the Councilors, shall be elected annually. The term of the Councilors shall be for three years. There shall be elected one Councilor for each of the ten districts. As nearly as possible, one-third of the members of the Council shall be elected each year. The Secretary and the Treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed. The President-elect shall automatically succeed the office of President at the conclusion of his one-year term of President-elect, or if the office of President shall be vacant."

4. Chapter III, Section 6 of the By-Laws to be amended to read: "The House of Delegates shall divide the State into ten Councilor districts, which shall consist of the following districts:

District 1: Dodge, Jefferson, Waukesha, Milwaukee, Walworth, Racine and Kenosha.

District 2: Fond du Lac, Sheboygan, Winnebago, Calumet, Manitowoc, Outagamie, Brown, Kewaunee and Door.

District 3: Green, Rock, Dane, Sauk, Columbia, Adams and Marquette.

District 4: Grant, LaFayette, Iowa, Crawford and Richland.

District 5: Vernon, La Crosse, Monroe, Juneau, Jackson, Trempealeau and Buffalo.

District 6: Green Lake, Waushara, Waupaca, Portage, Wood, Clark, Marathon and Lincoln.

District 7: Shawano, Oconto, Marinette and Florence.

District 8: Taylor, Price, Oneida, Langlade, Forest and Vilas.

District 9: Douglas, Bayfield, Ashland and Iron.

District 10: Pierce, Pepin, Eau Claire, St. Croix, Dunn, Chippewa, Polk, Barron, Rusk, Burnett, Washburn and Sawyer.

Each district, upon the call of its Councilor, or upon written demand of 25 per cent of its members, shall hold meetings at least once a year for the promotion of its best interests and that of the Society, and shall notify the State Society of the time, date and place of such meeting.

5. These amendments shall be disposed as is provided in Article XIII of the Constitution, and shall go into effect after their adoption at the annual meeting in 1949. By adoption the terms of the present Councilors in the present districts shall be terminated, and the newly elected Councilors will constitute the Council of the Society and shall serve in the manner provided in the Constitution and By-Laws of the Society.

Involving changes in the Constitution and By-Laws, the resolution was placed into the regular channels, to be published in the *Journal* and await action by the 1949 House of Delegates.

Message From Doctor Barker and Adjournmen

A congratulatory telegram from Dr. Creighton A. Barker of Connecticut was read by Doctor Stovall.

The meeting adjourned at 10:45 a.m.

THIRD SESSION

Tuesday, October 5

The third session of the House convened at 10:45 a.m., immediately following adjournment of the second session, Doctor Gundersen, Speaker of the House, presiding.

Report of Credentials Committee

The Committee on Credentials verified the registration of fifty-seven delegates and eight alternate delegates. In addition, nine alternate delegates and six Councilors had registered. The House, on motion of Chairman Carlson, seconded by Doctor Schaefer, voted to accept this total of sixty-five as the official roll of the final session, to stand for the entire session.

Report of Committee on Nominations

The following nominees were presented for official positions in the State Medical Society:

For the office of President-elect, Dr. J. W. Truitt of Milwaukee.

For the office of Speaker of the House, Dr. Gunnar Gundersen of La Crosse.

For the office of Vice Speaker, Dr. R. L. MacCornack of Whitehall.

For the office of Delegate to the AMA to succeed Dr. S. E. Gavin of Fond du Lac, Dr. S. E. Gavin of Fond du Lac.

And also to succeed Dr. J. C. Sargent, of Milwaukee, Dr. J. C. Sargent of Milwaukee.

For the office of alternate delegate to the AMA to succeed Dr. L. O. Simenstad, of Osceola, Dr. L. O. Simenstad of Osceola.

And also to succeed Dr. D. H. Witte, Milwaukee, Dr. D. H. Witte of Milwaukee.

The officers as nominated were unanimously elected.

The city of Milwaukee was selected by the committee as the meeting place for the Annual Meeting of the State Medical Society in 1949. A motion made by Doctor Cary to accept this suggestion was severally seconded and carried unanimously.

Doctor Truitt, the President-Elect, was introduced to the House:

Doctor Truitt: I believe the House has heard me often enough. The only thing I have to say is that I will serve this year's internship the best I know how, so that next year I will be able to carry on the thinking and the philosophy of Doctor Dawson, Doctor Stovall, and certainly the thinking of Doctor Doege, for peace and unity in the State of Wisconsin among every medical man, trying at the same time to further hasten the complete coverage of prepaid insurance to every person in the State.

Election of Councilors

The House then proceeded to the election of Councilors, with the following results:

In the First District, Dr. G. E. Eck of Lake Mills was elected for a full term.

In the Second District, Dr. T. C. Hemmingsen was reelected for a full term.

In the Eleventh District, Dr. V. E. Ekblad of Superior was reelected for a full term.

In the Twelfth District, Dr. N. J. Wegmann of Milwaukee was elected for a full term, and Dr. R. E. Galasinski, also of Milwaukee, was elected for a full term.

In accordance with Section 2, Article IX of the Constitution, the Third and Twelfth Councilor Districts were determined by the House to be each entitled to one additional Councilor.

Dr. Timothy Howard of Milwaukee was elected to fill the newly created position for the Twelfth District.

Dr. H. E. Kasten of Beloit was elected as the additional Councilor for the Third District.

Committee Appointments

At this point the appointments to committees of the Society were announced by President Doege. These appointments are published in full in the December 1948 issue of *The Wisconsin Medical Journal*, Medical Forum section.

Adjournement Sine Die and Vote of Thanks to the Medical Society of Milwaukee County

On motion of Doctor Cary, severally seconded, the House extended a rising vote of thanks to the Medical Society of Milwaukee County for their hospitality.

On motion of Doctor Kasten, severally seconded, the third session of the House of Delegates adjourned sine die at 10:20 a.m.

Attendance at House of Delegates, Milwaukee October 3, 4, 5, 1948

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	x	x	x
	W. E. Bargholtz, Ashland*	a	a	a
Barron–Washburn–Sawyer–Burnett	S. O. Lund, Cumberland	x	x	x
	O. E. Rydell, Rice Lake*	a	a	a
Brown–Kewaunee–Door	O. W. Saunders, Green Bay	x	x	x
	W. P. Tippet, Green Bay*	a	a	a
	A. J. McCarey, Green Bay	x	x	x
	W. A. Killins, Green Bay*	a	a	a
Calumet	A. C. Engel, New Holstein	a	a	a
	E. W. Humke, Chilton*	x	x	x
Chippewa	S. E. Williams, Chippewa Falls	x	x	x
	J. J. Sazama, Chippewa Falls*	a	a	a
Clark	M. V. Overman, Neillsville	x	x	x
	H. H. Christofferson, Colby*	x	x	x
Columbia–Marquette–Adams	R. B. Dryer, Poynette	x	x	x
	J. H. Houghton, Wisconsin Dells*	x	x	x
Crawford	E. H. Lechtenberg, Prairie du Chien	x	x	x
	T. F. Farrell, Prairie du Chien*	a	a	a
Dane	T. A. Leonard, Madison	a	a	a
	A. T. Schmedel, Stoughton*	x	x	a
	C. G. Reznicheck, Madison	x	x	x
	J. P. Malec, Madison*	a	a	a
	L. R. Cole, Madison	x	x	x
	J. H. Robbins, Madison*	a	a	a
	J. S. Supernaw, Madison	x	x	x

Society	Delegate	Sessions 1	2	3
	B. I. Brindley, Madison*	x	x	x
	L. V. Sprague, Madison	x	a	x
	J. A. Hurlbut, Madison*	x	x	x
Dodge	W. H. Costello, Beaver Dam	x	x	x
	A. B. Kores, Beaver Dam*	a	a	a
Douglas	C. W. Giesen, Superior	x	x	x
	Conrad Giesen, Superior*	a	a	a
Eau Claire–Dunn–Pepin	W. O. Paulson, Eau Claire	a	a	a
	C. M. Ihle, Eau Claire*	x	a	x
Fond du Lac	D. J. Twohig, Fond du Lac	a	x	x
	D. N. Walters, Fond du Lac*	x	x	a
Forest	G. E. Carroll, Laona	x	x	x
	O. S. Tenley, Wabeno*	a	x	x
Grant	J. D. Glynn, Lancaster	x	x	x
	M. W. Randall, Blue River*	a	a	a
Green	M. W. Stuessy, Brodhead	x	x	x
	F. J. Bongiorno, Albany*	a	a	a
Green Lake–Waushara	L. J. Seward, Berlin	a	x	x
	Mildred Stone, Berlin*	a	a	a
Iowa	W. P. Hamilton, Dodgeville	x	x	a
	E. J. Hohler, Mineral Point*	a	x	a
Jefferson	A. C. Nickels, Watertown	x	a	a
	C. J. Garding, Jefferson*	x	x	x
Juneau	C. A. Vogel, Elroy	a	a	a
	J. H. Hess, Mauston*	a	a	a
Kenosha	W. C. Stewart, Kenosha	x	x	x
	G. C. Schulte, Kenosha*	a	a	a
La Crosse	C. F. Midelfort, La Crosse	x	x	x
	P. V. Hulick, La Crosse*	a	a	a
Lafayette	N. A. McGreane, Darlington	x	x	x
	Mary P. Gratiot, Shullsburg*	a	a	a
Langlade	C. E. Zellmer, Antigo	x	x	x
	W. P. Curran, Antigo*	a	a	a
Lincoln	R. G. Baker, Tomahawk	x	x	x
	K. A. Morris, Merrill*	a	x	x
Manitowoc	E. C. Cary, Reedsville	x	x	x
	E. V. Huth, Valders*	a	a	a
Marathon	M. L. Jones, Wausau	x	a	a
	A. H. Stahmer, Wausau*	x	x	x
Marinette–Florence	H. W. Haasl, Peshtigo	x	x	a
	K. G. Pinegar, Marinette*	x	x	x
Milwaukee	H. H. Huber	x	x	x
	D. V. Elconin*	a	a	a
	L. J. Wegmann	x	x	x
	R. F. Purtell*	x	a	a
	E. L. Bernhart	x	x	x
	J. A. Enright*	a	a	a
	R. E. Galasinski	x	x	x
	W. T. Casper*	a	a	a
	T. J. Aylward	x	x	x
	A. J. Baumann*	a	a	x
	D. F. Pierce, Hales Corners	x	a	a
	S. W. Hollenbeck*	x	a	x
	Aaron Yaffe	a	a	a
	S. K. Pollack*	x	x	a
	H. W. Hefke	a	a	a
	H. W. Pohle*	x	x	x
	C. M. Echols	x	x	x
	J. G. Garland*	a	a	a
	L. J. Schneeberger	x	x	x
	M. J. Kuhn*	a	a	a
	J. V. Herzog	x	x	x
	J. D. Charles*	a	a	a
	M. Q. Howard	x	a	a
	L. J. Schwade*	a	a	a
	F. E. Drew	x	x	x
	Joseph Shaiken*	x	a	a
	Norbert Enzer	x	x	a
	R. W. Mann*	x	a	a
	W. J. Houghton	x	a	x
	G. S. Kilkenny*	a	a	a
	J. W. Fons	x	x	x
	E. R. Daniels*	a	a	a
	Forrester Raine	x	a	a
	H. N. Dricken*	x	a	a
	M. C. Borman	x	x	a
	J. P. Conway*	x	x	x
Monroe	J. S. Allen, Norwalk	x	x	x
	G. C. Devine, Ontario*	x	x	x
Oconto	R. J. Goggins, Oconto Falls	a	x	x
	A. F. Slaney, Oconto*	x	a	a
Oneida–Vilas	W. S. Bump, Rhinelander	x	x	x
	I. E. Schiek, Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	R. V. Landis, Appleton*	x	x	x
Pierce–St. Croix	C. E. McJilton, River Falls	x	x	x
	O. H. Epley, New Richmond*	a	a	a
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery*	a	a	a
Portage	E. E. Kidder, Stevens Point	x	x	x
	W. C. Sheehan, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	a	x	x
	L. E. Nystrom, Medford*	a	a	a
Racine	C. O. Schaefer, Racine	x	x	x
	G. N. Gillett, Racine*	a	a	a
	G. J. Schultz, Union Grove	x	x	x
	E. J. Schneller, Racine*	x	a	a
Richland	George Parke, Sr., Viola	x	x	x
	George Parke, Jr., Richland Center*	a	a	a

Society	Delegate	Sessions 1	2	3
Rock	H. E. Kasten, Beloit	x	x	x
	W. T. Clark, Janesville*	x	x	x
	W. A. Munn, Janesville	a	a	a
	R. A. Thayer, Beloit*	x	x	a
Rusk	L. M. Lundmark, Ladysmith	a	a	a
	Woodruff Smith, Ladysmith*	x	x	x
Sauk	Roger Cahoon, Baraboo	a	a	a
	J. F. Moon, Baraboo*	x	x	x
Shawano	A. A. Cantwell, Shawano	x	x	x
	E. E. McCandless, Wittenberg*	x	x	x
Sheboygan	P. B. Mason, Sheboygan	x	x	x
	J. A. Russell, Random Lake*	x	a	a
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	x	x	x
	Robert Krohn, Black River Falls*	a	x	x
Vernon	R. S. Hirsch, Viroqua	x	x	x
	F. F. Gollin, LaFarge*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	R. A. Mullen, Burlington*	a	a	a
Washington–Ozaukee	A. S. Barr, Port Washington	x	a	x
	T. D. Elbe, Thiensville*	x	x	x
Waukesha	E. C. Van Valen, Sussex	x	x	x
Waupaca	A. M. Christofferson, Waupaca	x	x	x
	F. J. Pfeifer, New London*	a	a	a
Winnebago	B. J. Hughes, Winnebago	x	x	x
	G. R. Anderson, Neenah*	a	a	a
Wood	R. E. Garrison, Wisconsin Rapids	x	x	x
	F. X. Pomainville, Wisconsin Rapids*	a	a	a
Section on Internal Medicine	F. L. Weston, Madison	x	x	x
	F. W. Madison, Milwaukee*	a	a	a
Section on Ophthalmology and Otolaryngology	L. A. Copps, Marshfield	x	x	x
	K. W. Covell, Racine*	x	x	a
Section on Orthopedics	R. P. Montgomery, Milwaukee	a	x	x
	L. D. Smith, Milwaukee*	a	a	a
Section on Radiology	L. V. Littig, Madison	x	x	x
	W. T. Clark, Janesville*	x	x	x

*—Alternate Delegate.
x—Present.
a—Absent.

Statement of Medical Examiners on Licensing Foreign Physicians

State Board of Medical Examiners
River Falls, Wisconsin
November 5, 1948.

Dear Mr. Crownhart:

This is in reply to your recent inquiry relative to the licensing of graduates of foreign universities.

The State Board of Medical Examiners has been advised by its legal counsel of its statutory duty in connection with examining and determining the qualifications of applicants for a license to practice medicine and surgery, or osteopathy and surgery, whose training has been acquired in a foreign country. It is the opinion of counsel that in discharging its statutory responsibility, the State Board of Medical Examiners must:

1. In no manner discriminate against American or Canadian applicants who, by law of their respective states, are required to have attained a minimum educational and professional training before being eligible to apply for a license. The board cannot apply a lesser standard to applicants having their medical education in foreign countries than is applied to graduates and citizens of this country.

2. Consider the duly filed application for license of an immigrant who has secured his first citizenship papers. In considering the application, the board, composed of men acting as officials of the state, must determine:

   a. Whether or not the school attended by the immigrant was a reputable institution at the time it granted the diploma and reputability involves such items as adequate staff, required attendance, and courses equivalent to those of the University of Wisconsin Medical School.
   b. Whether or not the immigrant has all educational prerequisites of equivalent value to those required of American or Canadian applicants. This determination must be exercised to the point of verifying the credentials and determining that the applicant actually was in attendance and took the course that the credentials represent.

The primary burden is upon the applicant to establish his qualifications. If the applicant has not satisfied the Board, the Board may make such other investigations as it may find desirable and reasonable, such as correspondence with officials of the school, diplomatic representatives, or other agencies whose certifications may be accepted as authentic.

Upon such preliminary determination to the reasonable satisfaction of the Board, it shall then examine the applicant as one entering upon the practice of medicine just as one would be examined from Wisconsin or Marquette; and such examination shall be non-discriminatory in any event. If the applicant successfully passes the examination, he may then be licensed.

The board has been further advised that it cannot issue any temporary permits to practice in Wisconsin and that the law under which it functions is designed for the protection of the public and is a reasonable exercise of the police power of the state in assuring to the public that unqualified practitioners will not be given the official seal of approval of the State of Wisconsin.

The statements included in this letter are not in any way confidential. We sincerely hope that your questions will be satisfactorily answered.

Yours sincerely
WISCONSIN STATE BOARD OF MEDICAL EXAMINERS
By C. A. DAWSON, *M. D.*, *Secretary*

SOCIETY PROCEEDINGS

Brown—Kewaunee—Door

Meeting at St. Mary's Hospital in Green Bay, members of the Brown–Kewaunee–Door County Medical Society held a joint meeting with the staff members of that organization on November 18. Following the 6:30 dinner, *Dr. M. L. Kuhs* discussed his recent trip to Alaska, illustrating his talk with colored slides taken on side-trips off from the Alaskan Highway and into the Arctic.

Chippewa

F. D. MURPHY

Dr. Rex E. Graber, Chippewa Falls, was named president of the Chippewa County Medical Society at a meeting held at the Hotel Northern, Chippewa Falls, on October 19. Other new officers are *Drs. J. A. Kelly*, vice-president; *William Janc*, secretary, *S. E. Williams*, delegate; and *J. J. Sazama*, alternate delegate. All those named to positions are from Chippewa Falls. Guest speaker for the meeting was *Dr. F. D. Murphy*, chief of staff of St. Joseph's Hospital in Milwaukee and professor of medicine at Marquette University School of Medicine. He presented a paper on "Renal Disease." A report on the Annual Meeting of the State Medical Society was presented by *Dr. S. E. Williams*, delegate.

Crawford

The regular monthly meeting of the Crawford County Medical Society was held on November 17 at the San Hotel in Prairie du Chien.

Fond du Lac

Guest speaker at the Fond du Lac County Medical Society on October 28 was Dr. N. C. Mead of Evanston, Illinois. The meeting was held at the Hotel Retlaw in Fond du Lac. Doctor Mead entitled his paper "The Painful Shoulder." Members of the Society voted approval of the mobile x-ray project (anti-tuberculosis) at the meeting.

Kenosha

When members of the Kenosha County Medical Society held their dinner meeting at the Elks Club in Kenosha on November 4, Dr. Philip Thorek, widely known surgeon from Chicago, spoke on the subject "Intestinal Obstructions," illustrating his talk with motion pictures. Doctor Thorek is assistant professor of surgery at the University of Illinois College of Medicine and associate professor of surgery at the Cook County General Hospital.

Eau Claire—Dunn—Pepin

P. A. DUEHR

Members of the Eau Claire – Dunn – Pepin County Medical Society gathered at the Elks Club in Eau Claire on November 29 to hear *Dr. Peter A. Duehr*, Madison, speak on the "Recognition and Therapy of Some Common Ophthalmological Problems." Doctor Duehr is assistant professor of ophthalmology at the University of Wisconsin Medical School.

Pierce—St. Croix

The Hudson Hotel in Hudson was the meeting place for the Pierce–St. Croix County Medical Society on November 16. Guest speaker for the occasion was *Dr. Llewellyn R. Cole*, coordinator of graduate medical education at the University of Wisconsin Medical School, who discussed "What the Public Thinks of Its Doctors."

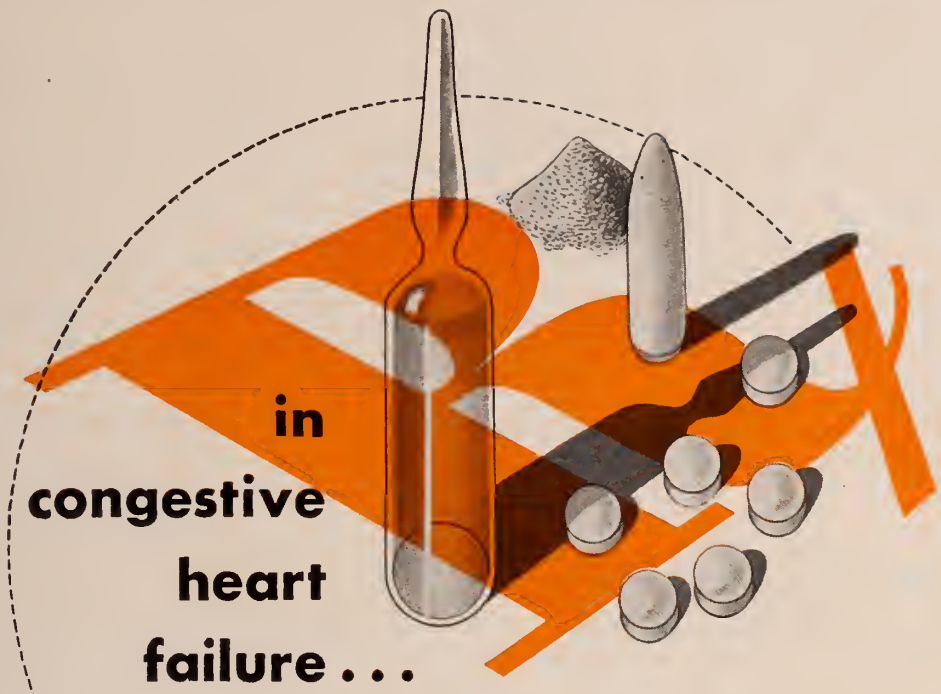
Richland

T. C. ERICKSON

Meeting at the Richland Hospital in Richland Center on November 9, members of the Richland County Medical Society heard a talk by *Dr. T. C. Erickson* of Madison. Doctor Erickson, who is associate professor of surgery at the University of Wisconsin Medical School, chose "Intracranial and Spinal Injuries" as his topic for discussion.

Trempealeau—Jackson—Buffalo

Dr. Erwin C. Schmidt, professor of surgery at the University of Wisconsin Medical School, spoke at the November meeting of the Trempealeau–Jackson–Buffalo County Medical Society held at St. Joseph's Hospital in Arcadia on November 18. Doctor Schmidt, a native of Arcadia, pointed out the



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SEARLE

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1. Orgain, E. S.: The Treatment of Congestive Heart Failure, Narth Caralina M. J. 8:125 (March) 1947.

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Prescribe Journal-advertised products and you prescribe the best.

"Newer Aspects of Surgery." This meeting is a yearly feature when Doctor Schmidt visits his home town and renews old acquaintances.

Washington—Ozaukee

Following a dinner at which members of the Auxiliary were guests, members of the Washington–Ozaukee County Medical Society chose their officers for the coming year on November 18 at the Republican Hotel in Kawaskum. The following physicians were named to office: *Dr. E. L. Bernhardt,* West Bend, president; *Dr. A. H. Barr,* Port Washington, vice-president; *Dr. R. H. Driessel,* West Bend, secretary-treasurer *Dr. T. D. Elbe,* Thiensville, delegate; *Dr. F. I. Bush,* West Bend, alternate delegate; and *Drs. E. C. Quackenbush,* Hartford, *C. C. Stein,* Port Washington, and *W. A. Nielsen,* West Bend, censors. Guest speaker for the evening was *Dr. Kenneth Karr,* Milwaukee, who discussed the "Management of Diabetes."

On October 28 the Society met at St. Joseph's Hospital in West Bend to hear *Dr. L. H. Hirsh* of Milwaukee speak on the "Differential Diagnosis of Chest Disease." At this meeting it was decided to invite the State Board of Health mobile x-ray unit into the county.

Waukesha

Dr. Gwilym Davies, Waukesha, was named president of the Waukesha County Medical Society when that organization held its annual business meeting on December 1. Other members elected to offices were *Dr. J. D. Wilkinson,* Oconomowoc, vice-president; *Dr. F. L. Grover,* Hartland, secretary and treasurer; *Dr. L. C. J. Olsen,* Delafield, censor; *Dr. E. C. Van Valin,* Sussex, delegate; and *Dr. R. H. Schmidt, Jr.,* Statesan, alternate delegate.

Winnebago

A pioneer in the development of equalizing pressure chambers, Dr. Alvin L. Barasch from the medical department of Columbia University, New York, addressed the meeting of the Winnebago County Medical Society held at Sunny View Sanatorium, Winnebago, on November 4. The title of his discussion was "Total Lung Rest by the Use of the Barasch Immobilization and Lung Chamber, with Demonstrations." He presented reports of cases and gave members an opportunity to see the chamber in action. Sunny View Sanatorium owns three of the twenty chambers in the country.

Wisconsin Chapter of American College of Chest Physicians

The fourth annual meeting of the Wisconsin Chapter of the American College of Chest Physicians was held at the Hotel Schroeder in Milwaukee on October 3. The following officers were elected for 1948–1949: directors, *Drs. Alfred A. Busse,* Jefferson, and *Ethan B. Pfefferkorn,* Oshkosh; president, *Dr. George H. Jurgens,* Milwaukee; vice-president, *Dr. John K. Shumate,* Madison; and secretary-treasurer, *Leon H. Hirsh,* Milwaukee.

Wisconsin Surgical Club

The fall meeting of the Wisconsin Surgical Club was held November 27 in Racine, where members were guests of *Dr. Russell M. Kurten.* Feature of the meeting was the presentation of a silver supper dish with facsimile signatures of each member of the club engraved on it to *Dr. Joseph F. Smith* of Wausau, in appreciation of his twenty-six years of service as secretary of the Club. Presentation was performed by *Dr. F. Gregory Connell* of Oshkosh. *Dr. Thomas J. Snodgrass,* Janesville, now holds the office of secretary recently vacated by Doctor Smith.

The following scientific program was presented by physicians from Racine:

"Special Problems in Preoperative and Postoperative Cases of Pediatric Surgical Patients," by *Dr. Niels Low*

"The Acute Knee Joint," by *Dr. Charles Christenson*

"Pulmonary Complications in the Postoperative Period," by *Dr. George N. Gillett*

"Gastric Tumors of Mesenchymal Origin," by *Dr. Edmund Schacht*

"Ulcerative Colitis," by *Dr. Louis J. Kurten*

"Diverticulitis of the Colon," by *Dr. Russell M. Kurten*

Dinner was served at noon at the Somerset Club. Guests of the Club were *Drs. Warner S. Bump,* Rhinelander; *C. S. Rife,* Milwaukee; and *Laurence Quigley,* Green Bay.

POSTGRADUATE COURSE IN DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians and the Laennec Society of Philadelphia announce a Postgraduate Course in Diseases of the Chest to be held at the Warwick Hotel, Philadelphia, February 28—March 5, 1949. This course will emphasize the recent developments in all aspects of diagnosis and treatment of diseases of the chest.

The course is open to all physicians, although the number of registrants will be limited. Applications will be accepted in the order in which they are received. The tuition fee is $50.00.

Application may be made through the executive offices of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

In Angina Pectoris

In Angina Pectoris the incapacitating symptoms frequently may be prevented by appropriately regulated administration of a vasodilator having a sustained effect. This type of medication may be indicated:

FOR THE PERSON

- *who suffers "indigestion" and "gas" after a heavy meal.*
- *who is compelled to stop and rest when climbing a flight of stairs.*
- *who is stricken with precordial pain on unusual exertion or emotion, or when exposed to cold.*

The vasodilatation produced by Erythrol Tetranitrate Merck (Erythrityl Tetranitrate Tablets U.S.P.) begins about 15 minutes after administration, and lasts from 3 to 4 hours.

Experience has shown that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of organic nitrates or nitrites. For prophylactic purposes—to control anticipated paroxysms—the delayed but prolonged action of Erythrol Tetranitrate is reported as especially useful. Erythrol Tetranitrate, because of its slow and prolonged action, also is of value for preventing nocturnal attacks.

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News Items and Personals

Ten Wisconsin Physicians Join American College of Surgeons

Ten Wisconsin physicians were received into fellowship in the American College of Surgeons at the convocation during the clinical congress of the organization in Los Angeles on October 22. They were *Drs. George H. Anderson,* Stevens Point; *William A. Dafoe,* Appleton; *Joseph F. Egan,* La Crosse; *Charles Fidler,* Milwaukee; *Erwin E. Grossmann,* Milwaukee; *Howard C. High, Jr.,* Milwaukee; *Jacob E. Kaufman,* Green Bay; *Jack A. Killins,* Green Bay; *Robert E. McDonald,* Milwaukee; and *Benedict R. Walske,* Milwaukee.

In order to qualify for fellowship, a surgeon must be a graduate of an acceptable medical school; be licensed to practice in his respective state, province, or country or be a medical officer of a federal service; have three or more years of training in surgery in hospitals approved by the College; devoted at least half of his practice to surgery; and have spent seven or more years after graduation in medicine, devoted to special training and practice.

International College of Physicians Names State Members

Among the physicians elected to the International College of Surgeons at its thirteenth annual assembly and convocation in St. Louis November 15–19 were eight from Wisconsin. *Drs. Harold J. Dvorak,* Milwaukee, and *Arnold S. Jackson,* Madison, were elected fellows in the organization; *Drs. John T. Sprague,* Madison, and *Frank B. Sazama* and *Stephen E. Williams,* Chippewa Falls, associate fellows; and *Drs. Norman A. Frankenstein,* Madison, *Raymond Yost,* Manitowoc, and *William R. Marquis,* Waunakee, affiliate fellows.

At the convocation, over 800 surgeons were received into the organization. Surgeons from eleven foreign countries addressed the meeting, at which 4,000 surgeons were present.

Drs. D. W. Curtin and R. S. Gage Become Associates in Practice

Drs. D. W. Curtin and R. S. Gage of Kimberly became associated in medical practice on November 11, when they opened a new medical building in that city. The building is equipped with a complete clinical laboratory, an x-ray department, and facilities for some physiotherapy work. Doctor Gage recently completed his internship at St. Elizabeth's Hospital in Appleton.

Dr. and Mrs. F. W. Hammond Observe Golden Anniversary

Dr. and Mrs. *F. W. Hammond* of Manitowoc celebrated their golden wedding anniversary on November 17. The doctor also was recently honored by the Lions Club of that city, when they presented him the organization's distinguished service award naming him Manitowoc's outstanding citizen of 1948. He has been in the practice of medicine for more than fifty years, thirty-four of which have been spent in Manitowoc. A graduate of Milwaukee Medical College in 1898, he is a former president of the Manitowoc County Medical Society and of the staff of Holy Family Hospital.

Dr. Dayton Hinke Joins Staff of Clinic at Richland Center

Dr. Dayton Hinke, who has held a fellowship in the department of surgery at the University of Minnesota hospitals during the past year, recently joined the staff of the Edwards Clinic in Richland Center. Following graduation from the University of Pennsylvania School of Medicine in 1944, he served his internship at Luther Hospital, Eau Claire, before joining the Army Medical Corps. He was discharged from military service with the rank of captain.

Dr. J. J. Sevenants Opens Dermatologic Practice in La Crosse

Dr. John J. Sevenants, formerly located in Minneapolis, recently opened a practice in dermatology in La Crosse. A graduate of the University of Minnesota Medical School, Doctor Sevenants served in the Army Medical Corps for three years. Following his discharge he served a residency in dermatology at the University of Minnesota.

Dr. R. K. Irvine Leaves Practice to Specialize

A practitioner in Manawa for twenty-four years, *Dr. R. K. Irvine* recently left that community to begin a residency in internal medicine in Philadelphia. Doctor Irvine began practice in Manawa in 1924, following graduation from the University of Pennsylvania School of Medicine and internship in Philadelphia. He was associated in practice with his father, the late Dr. W. Irvine, until the death of the latter in 1945. Doctor Irvine served five successive terms as president of the Waupaca County Medical Society.

Dr. G. A. Senn Wins Second Prize in Art Contest

In an exhibition of over one thousand oil paintings, sculptured works, and drawings sponsored by Mead Johnson and Company, *Dr. George A. Senn* of Green Bay won second prize and the blue seal cup and certificate of the American Physicians Art Association at the tenth annual exhibition in Chicago early in November. The prize was won with a wood carving "Sir Galahad (Abbey)" in the sculpture class. He also entered a leather tooling work, "Book Cover."

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THIRD DISTRICT PHARMACISTS

The pharmacies listed in this section have been recommended as rendering the type of prescription service in keeping with high medical standards.

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THE PRESCRIPTION PHARMACY
Samuel R. Chechik, Ph.D.
20 South Carroll St. Phone: Badger 755
"The Park Hotel Building", Madison 3, Wis.

Biologicals—Chemicals—Drugs
FIRST CENTRAL DISPENSARY
602 First Central Building
Phone: Badger 7929
RELIABLE PRESCRIPTION SERVICE

Prescription Service at
RENNEBOHM
Better Drug Stores
is always
100% Dependable
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MALLATT PHARMACY
Prescription Druggist
3410 Monroe Street, Madison, Wisconsin
Phone: Fairchild 3400

Dr. T. S. Rosen Speaks to Visiting Nurses Association

Dr. T. S. Rosen of Eau Claire was the guest speaker at the Visiting Nurses Association when that organization met in Eau Claire on November 9. In his address entitled "Medical-Legal Problems," Doctor Rosen warned that communities should be awakened to the dangers of drivers under the influence of liquor and that more severe penalties should be given to repeated offenders. The doctor is a pathologist at Luther and Sacred Heart hospitals.

Dr. Harry Schaefer Appointed to Hospital Staff

Dr. Harry Schaefer of Manitowoc was recently appointed assistant to *Dr. J. M. Kelley* at the Maple Crest Sanatorium at Whitelaw. Doctor Schaefer, a graduate of Marquette University School of Medicine, located in Manitowoc last March.

AND ABOUT THE THIRD AND TWELFTH DISTRICTS:

"With a marked concentration of physicians in the Third and Twelfth Councilor Districts, the *Journal* is assembling all news items pertaining to activities of physicians in Dane, Rock, Green, Columbia, Sauk, Marquette, Adams, and Milwaukee Counties and presents them together. The *Journal* urges county secretaries to send personal items of interest. Such notices should reach our office by or before the fifteenth of each month before publication."

—EDITOR'S NOTE

SOCIETY PROCEEDINGS

Columbia—Marquette—Adams

Members of the Columbia – Marquette – Adams County Medical Society met at the Hotel Portage in Portage on November 9 for a business session. Topics discussed were obtaining a psychiatrist for the county and twenty-four hour service for patients.

Dane

The Dane County Medical Society held its November meeting in conjunction with the annual Dearholt Day at the Madison Club on November 23. Guest speakers were Dr. Edith M. Lincoln, assistant professor of pediatrics at the New York University College of Medicine, and Dr. Florence B. Seibert, associate professor of biochemistry at the University of Pennsylvania. Doctor Lincoln spoke on "Chemotherapy in the Treatment of Tuberculosis in Children," and Doctor Seibert discussed "Serum Changes of Diagnostic and Prognostic Significance in Tuberculosis."

Green

Meeting at the Ludlow Hotel in Monroe on October 12, members of the Green County Medical Society heard an address by Harold Deutsch, Ph.D., associate professor of physiological chemistry at the University of Wisconsin. His paper was entitled "Recent Work in Blood Proteins."

Rock

When the Rock County Medical Society met in Beloit on October 26, its members became acquainted with the Wisconsin Interscholastic Athletic Association student coverage program. Present to discuss the program were Mr. Paul Neverman, Marinette, executive secretary of the organization, and *Dr. C. M. Carney*, Beloit, a member of the W.I.A.A. advisory board. The following officers were named as the result of an election held at the meeting: president, *Dr. R. A. Thayer*, Beloit; vice president, *Dr. V. W. Koch*, Janesville; secretary-treasurer, *Dr. G. H. Peterson*, Beloit; censor, *Dr. S. A. Freitag*, Janesville; trustee, *Dr T. O. Nuzum*, Janesville; delegates, *Drs. W. A. Munn*, Janesville, and *H. E. Kasten*, Beloit; and alternate delegates, *Drs. W. T. Clark* and *S. A. Freitag*, both of Janesville.

THIRD DISTRICT NEWS

Dr. S. C. Rogers Opens Office in Madison

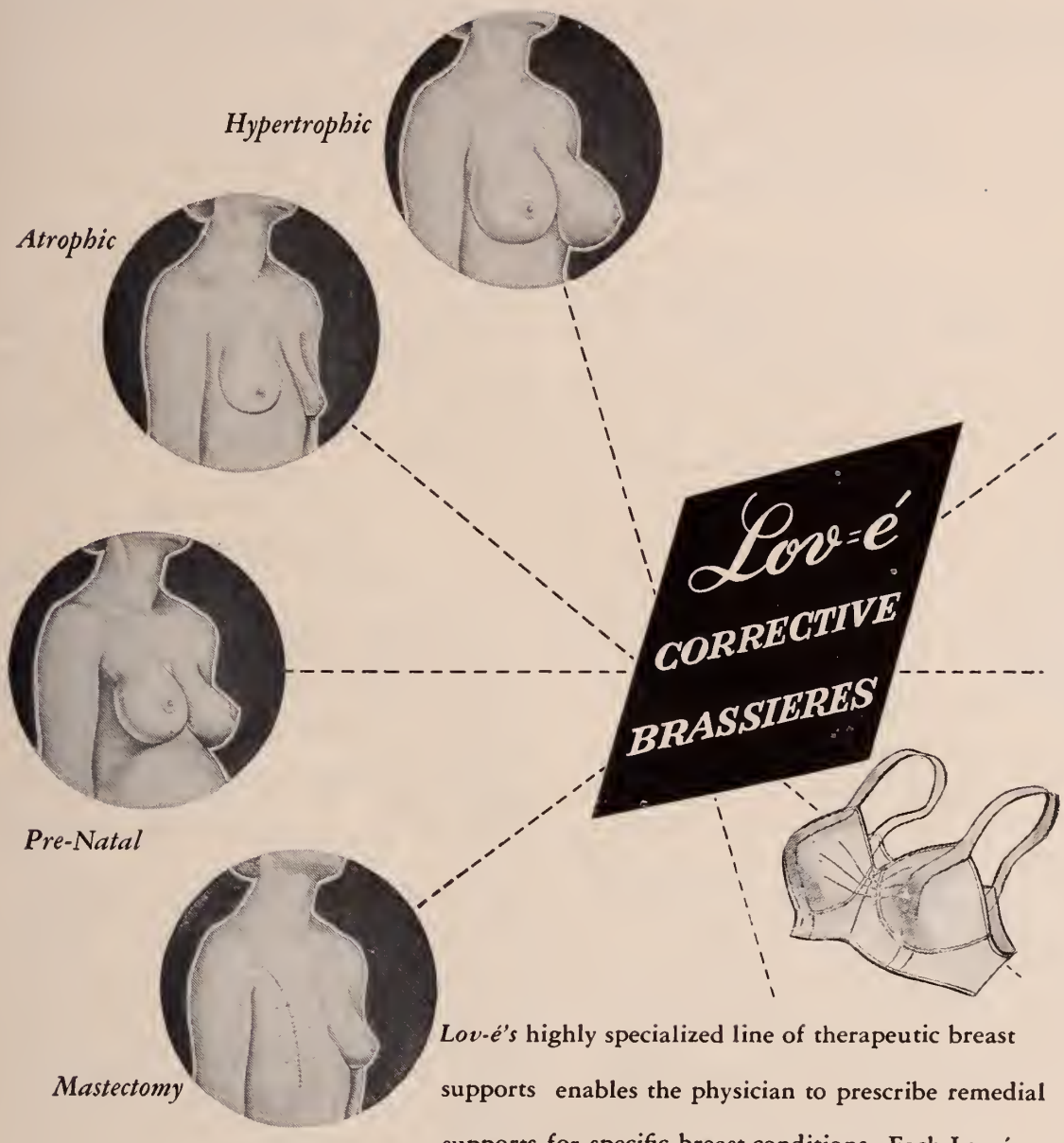
Dr. Sion C. Rogers, who formerly practiced in Dayton, Ohio, recently opened an office in the Tenney Building, Madison, for the practice of orthopedic surgery. A graduate of the University of Wisconsin Medical School, Doctor Rogers returned after his internship to serve a three year residency in bone and joint surgery at the State of Wisconsin General Hospital. He served in the Army Medical Corps for four years prior to practicing in Dayton.

Madison Doctors Speak at Railway Surgeons Meeting

Drs. George H. Ewell and Wayne B. Slaughter, Madison, addressed the sixtieth anniversary meeting of the American Association of Railway Surgeons in Chicago on November 21. Doctor Ewell is a member of the staff of Jackson Clinic, and Doctor Slaughter is associate professor of plastic surgery at the University of Wisconsin Medical School.

Nutritionist from Nanking, China, Speaks at Medical School

Director of the Institute of Nutrition in Nanking, China, Dr. H. C. Hou, spoke on "Certain Nutritional Deficiency Disease Problems in China" at the Serv-



Lov-é's highly specialized line of therapeutic breast supports enables the physician to prescribe remedial supports for specific breast conditions. Each Lov-é brassiere is custom-fitted inch by inch to the patient's personal measurements . . . and in exact accordance with your instructions. *Lov-é* Corrective Brassieres are available for immediate order in appropriate long or short models, from more than 500 bust-cup-torso size variations.

Also available: sleeping brassieres, hospital binders, artificial breasts, anatomically designed muscle pads and maternity garter supports.

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ice Memorial Institutes Building of the University of Wisconsin Medical School on November 17. Doctor Hou, a medical graduate of Peking University, is working in the department of biochemistry of the University of Wisconsin before returning to his country.

Professor of Neurophysiology Presents Public Lecture

Dr. Clinton N. Woolsey, newly appointed Charles Sumner Slichter Research Professor of Neurophysiology at the University of Wisconsin Medical School lectured on the "Newer Studies on the Localization of Function in the Brain" at the Service Memorial Institutes Building of the University of Wisconsin on December 7. The Charles Sumner Slichter Research Professorship was recently established by the Wisconsin Alumni Research Foundation as a memorial to the late Charles Sumner Slichter, former dean of the graduate school and professor of mathematics at the University of Wisconsin.

Doctor Woolsey came to the University from Johns Hopkins University School of Medicine in Baltimore, where he served as professor of physiology.

TWELFTH DISTRICT NEWS

Dr. Irwin Schulz Named to Position By Railway Surgeons

Dr. Irwin Schulz, Wauwatosa, was elected vice-president of the American Association of Railway Surgeons on November 23 at its sixtieth annual convention in Chicago. Doctor Schulz is a surgeon for the Northwestern and Milwaukee roads.

At the meeting, *Dr. Francis D. Murphy* of Milwaukee presented a paper on "Hypertension and Some of Its Complications." Doctor Murphy is a consulting internist for the Milwaukee Road.

Dr. K. A. Seifert Certified By Specialist Board

Dr. Kenneth A. Seifert. West Allis, was recently certified by the American Board of Surgery. Doctor Seifert has been practicing in Milwaukee since 1945, following his discharge from the Army Medical Corps.

SOCIETY PROCEEDINGS

Milwaukee Academy of Medicine

A guest speaker from the Mayo Clinic in Rochester, Minnesota, Dr. Herman J. Moersch, was present at a meeting of the Milwaukee Academy of Medicine at the University Club of Milwaukee on November 16. Doctor Moersch spoke on "Diseases of the Esophagus and Their Treatment."

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society held a dinner meeting at the University Club of Milwaukee on November 18. Following the dinner, papers were presented by four physicians: *Dr. J. A. Kindwall,* Wauwatosa, pointed out his "Observations on Scandinavian Clinics"; *Dr. S. A. McCormick,* Madison, discussed "Some Thoughts on Motivation"; *Dr. C. R. Headlee,* Milwaukee, spoke on "Lay Group Contacts"; and *Dr. J. L. Kinsey,* Milwaukee, talked on "Personality Traits Among Birds."

Milwaukee Oto-Ophthalmic Society

Dr. James Lebensohn, assistant professor at Northwestern University Medical School, was present at the November 23 meeting of the Milwaukee Oto-Ophthalmic Society at the Milwaukee Athletic Club to discuss the subject of "Bifocals." *Dr. Gerhard Straus,* Milwaukee, presented a report of a case of "Bacillus Proteus Otitis Media with Multiple Abscesses."

SOCIETY RECORDS

New Members

James J. Klobucar, 101 North Washington, Green Bay.

A. Wilson Brown, 413 Fourth Street, Algoma.

John W. Moon, 101 Fourth Street, Baraboo.

Max Baumeister, Jr., 109 North Seventh Street, Madison.

Edward L. Doermann, 1300 University Avenue, Madison.

Isadore E. Kolman, Madison General Hospital, Madison.

Edward M. Burns, 1300 University Avenue, Madison.

William G. Healy, 461 North Few Street, Madison.

Hubert C. Ashman, 16 South Henry Street, Madison.

William A. Tanner, 1922 University Avenue, Madison.

Robert E. Schmidt, 5000 West Chambers Street, Milwaukee.

Hanno H. Mayer, 2200 West Kilbourn Street, Milwaukee.

David A. Cofrin, 1105 South Jackson Street, Green Bay.

Robert W. Schroeder, 39 South Main Street, Fond du Lac.

Edward W. Vetter, Fond du Lac Clinic, Fond du Lac

Martin H. Sahs, 514 River Street, Spooner

Walter F. Larrabee, Jr., Schiek Clinic, Rhinelander.

Edward C. Jarvis, Hillsboro.

Changes in Address

D. R. Searle, Superior, to Safety Harbor, Florida.

J. W. Guepe, Lake Geneva, to 11675 Lake Shore Drive, Whitmore Lake, Michigan.

P. Z. Reist, Wausau, to 257 Forsythe Street, Girard, Ohio.

A. E. Muccilli, Spooner, to 149 North Sirrene Street, Mesa, Arizona.

Pharmaceutical News for Physicians

To the Members of the State Medical Society of Wisconsin

A Merry Christmas and A Happy New Year

From the members of the Wisconsin Pharmaceutical Association.

"We pledge our continued cooperation with the medical profession in the interests of good health."

Every three months the Wisconsin Pharmaceutical Association presents two pages of Pharmaceutical news in The Wisconsin Medical Journal which is of interest to Wisconsin physicians.

PHENOSULFAZOLE IN POLIOMYELITIS — A new sulfonamide has been developed which has successfully halted poliomyelitis in mice and it is now under study in humans. Until these results are known high hopes must be curbed.

A preliminary study of phenosulfazole in humans has been initiated but at present the only goal to be accomplished will be the determination of the pharmacological action and whether or not the drug warrants continued study. No objective and valid statement can be made at present regarding its value in this direction. Poliomyelitis varies widely in animals and in man. There are at least a dozen strains known. Phenosulfazole may prove to be effective against only one of these strains and not against the others. Unfortunately the lay press has to some extent led the public to believe that a "polio cure" has been found and consequently many families who have suffered from the condition may feel that they have been victims of professional neglect. The pharmacist will aid the physician by explaining this situation to his patrons should the question arise.

BACITRACIN AND AUREOMYCIN — Two antibiotics have recently been received by the Food and Drug Administration for general marketing—bacitracin and aureomycin. Each of the drugs has demonstrated therapeutic usefulness in a number of specific infections. These drugs may be available by the time you read this.

HUMAN RESEARCH — Dr. A. C. Ivy has suggested observance of the following three rules before a new drug or operation is tried on human patients: (1) All subjects must be volunteers who have been fully informed of the hazards, if any; (2) the experiment to be performed must be based on sufficient animal research to afford maximum safety and a reasonable guarantee that the result will justify the experiment; (3) the experiment must be performed by qualified scientists who should, whenever possible, also serve as volunteers as evidence of the necessity of the experiment and their willingness to experience discomfort, along with others, for the sake of a solution to the problem.

DIHYDROSTREPTOMYCIN HYDROCHLORIDE NOW AVAILABLE — Dihydrostreptomycin is a potent antibiotic compound derived from streptomycin by reduction with hydrogen. Antibacterial activity in tuberculosis usually parallels that of streptomycin. Resistant strains of organisms appear to develop as rapidly as with streptomycin.

Dihydrostreptomycin can be given safely in larger doses and for more prolonged periods, an important advantage in treating tuberculosis. Patients showing allergic reactions to streptomycin have been able to continue therapy with the dihydro form.

Dihydrostreptomycin is stable in solution—no appreciable loss of potency at room temperature for as long as one month, and stable as a powder at room temperature for 18 months.

Dosage is similar to that for streptomycin. Daily doses of 2 grams of the dihydro form may be given safely for periods equal to those in which streptomycin has been restricted to 1 gram a day, provided there is no renal dysfunction. Average dosage—1 to 2 grams daily in divided doses every 12 hours. Duration varies with type of tuberculosis.

It is administered only intramuscularly. Pending more clinical experience with Dihydrostreptomycin, it should not be given intravenously or intrathecally.

Caution: All patients receiving Dihydrostreptomycin should be carefully observed for untoward reactions, particularly signs of eighth nerve damage (vertigo, tinnitus, deafness), paresthesias of the face, renal irritation, skin eruptions, headache, pain at site of injection, and gastric disturbances. Clinical judgment as to termination of therapy must be exercised when side-effects occur.

OUT OF STATE DANGEROUS DRUG PRESCRIPTIONS — The Professional Relations Committee of the Wisconsin Pharmaceutical Association recently completed a nation-wide survey determining which states have Dangerous Drug Laws prohibiting the filling of dangerous drug prescriptions written by physicians not residing in their own state. The survey showed that five states—California, Florida, Illinois, New Jersey, and Michigan restrict the filling of prescriptions for dangerous drugs to scripts written by doctors practicing in their own state. One other state, Minnesota, has a Barbiturate Law which limits the filling of barbiturates "except on the written prescription of a Doctor of Medicine, Doctor of Dental Surgery, or Doctor of Veterinary medicine, lawfully practicing his profession in this state."

The degree of enforcement of these laws was not determined by the survey, but such laws do exist. Answers from many of the other states indicated that where no specific restrictions existed, the so-called dangerous drug prescriptions were handled in much the same manner as narcotic prescriptions. The pharmacist either satisfied himself that the prescription was bona fide, or in case of doubt refused to fill it.

The conclusions to be drawn from the survey are that there are varying state pharmacy laws, interpretations, and degrees of enforcement throughout our country. In many cases if the laws were to be strictly enforced, difficulty and misunderstanding might occur where cities are close to state boundary lines; for example, located just across a river from a sister city in another state. As the laws do exist, however, it is advisable in many cases to warn prospective travelers to take an adequate supply of medication with them or to make necessary arrangements with their physician to have additional supplies mailed to them along the way to forestall any difficulty or inconvenience that might arise.

Full details regarding this survey are on file in the offices of the Wisconsin Pharmaceutical Association, 625 N. Milwaukee St., Milwaukee, Wis.

SENSIBLE ASPIRIN DOSAGE — Overdoses of aspirin can be very dangerous when given to infants. Dr. Murray H. Bass of New York reports three deaths of infants under one year old from aspirin poisoning. He thinks that mothers have become so used to taking aspirin that they do not think of it as being poisonous. Aspirin is prescribed a great deal by pediatricians, but the prescribed dosage, either through ignorance or indifference, is not always adhered to. Dr. Bass says the proper dosage for babies is one grain per year of age, given about four times daily. He thinks that people often fail to realize that the ordinary aspirin tablet contains five grains. The use of a one grain aspirin tablet for children might eliminate this hazard.

ALUMINUM HYDROXIDE PASTE SOOTHES PRURITIS DISCOMFORT — Aluminum hydroxide gel gives excellent results in many cases of anal pruritis, according to Drs. H. H. F. Friedman, B. F. Haskell and W. J. Snape.

Local application of a paste made from aluminum hydroxide gel brought prompt sustained relief to 93 of 98 patients with the "moist" type of pruritis, these investigators state in the *American Journal of Digestive Diseases*, 15:56, 1948.

The treatment had little or no effect in "dry" cases of pruritis, they found. Only two of 36 patients with the latter type were benefited. The aluminum hydroxide was provided in a thick paste.

DO YOU RECALL? — AMIDONE HYDROCHLORIDE is the analgesic drug, developed in Germany, which is marketed in the United States under the names, Adanon, Dolophine, and Methadon.

AQUEOUS PENICILLIN PROLONGS BLOOD LEVELS — Penicillin which is administered in water, but which provides blood levels from a single shot comparable to those achieved with the oil-and-wax form, is appearing on the market.

These products comprise procaine penicillin in the dry form, plus an innocuous suspending agent. When sterile distilled water or normal saline solution is added, the procaine penicillin enters into a homogenous suspension.

This form is said to provide effective blood levels for 24 hours following a single injection. Solutions are reported to remain stable for about a week and injection is relatively painless. With the development of these aqueous products, penicillin dosage forms appear to have turned a full cycle. The first form, of course, was the sodium salt packed in dry form, to which water was added just before use. This form required frequent injections (every three or four hours, around the clock) in order to maintain blood levels.

Following this, there was developed the well-known formula, comprising an oil-and-wax suspending medium. While this medium provided prolonged blood levels, from a single shot, injections were often painful. Moreover, the suspension had to be warmed to make it fluid for injection.

Next appeared a free-flowing oil-and-wax vehicle, requiring no warming. This product required the use of dry syringe for administration.

Later it was found possible to suspend procaine penicillin in oil and attain prolonged blood levels without the use of wax, so that injections were less painful.

Still another product in the sequence is procaine penicillin in oil with aluminum monostearate to prevent settling.

The recently announced products complete the cycle to an aqueous vehicle.

VITAMIN B_{12} IN ANEMIA — In 1926 the specificity of liver in the dietary treatment of pernicious anemia was first described. Since that time research has been directed towards the purification of the principle or principles responsible for this therapeutic property, as it was evident that this objective could be effected. One of the difficulties in seeking such purification methods has been the lack of a biological assay. As the fractions were purified it was thus difficult to find sufficient patients with pernicious anemia on whom the fractions could be tested.

As a result of a long series of research studies a recent announcement was made which indicated the successful isolation from liver of a crystalline compound which, in microgram quantities, produces positive hematological response in initial tests in patients with addisonian pernicious anemia. This crystalline compound, named "vitamin B_{12}" has been found to possess high activity for the growth of LACTOBACILLUS LACTIS Dorner. Consequently, that organism was selected for use as the medium for its testing.

The factor was named VITAMIN B_{12} rather than "anti-pernicious anemia principle," because its biological role in the treatment of pernicious anemia or other disease is yet to be determined. Therefore vitamin B_{12} connotes only nutritional significance at present. In the future a name based upon chemical structure may be designated. It is not commercially available.

APh.A. AND AMA ARE WORKING TOGETHER on a study of ophthalmological solutions. Study started in APhA labs on question of isotonic adjustment of these preparations. To secure clinical testing, APhA took problems to AMA's Therapeutic Trials Committee, which arranged for clinical work to be done at the University of Illinois. APhA is footing the cost. Results may settle current controversy over the necessity for isotonic adjustment of ophthalmological preparations.

only two or three drops

PRIVINE

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high potency Only two or three drops of the 0.05 per cent solution of Privine hydrochloride usually give prompt and complete relief of nasal congestion and hypersecretion.

prolonged action The effect of each application of Privine provides two to six hours of nasal comfort, thus avoiding the inconvenience of frequent re-application.

bland and non-irritating Privine is prepared in an isotonic aqueous solution buffered to a pH of 6.2 to 6.3. Artificial differences in osmotic pressure between solution and epithelium are avoided; stinging and burning are usually absent.

relatively free from systemic effects Although a sedative effect is occasionally noted in infants and young children — usually after gross overdosage — Privine is generally free of systemic effect. The absence of central nervous stimulation permits the use of Privine before retiring without interfering with restful sleep.

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Privine 0.05 per cent for all prescription purposes; 0.1 per cent strength reserved for office procedures.

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G. J. Hugo, Kaukauna, to 701 Parkwood Drive, Cleveland, Ohio.

J. E. Clifford, Council, Idaho to 311 West Idaho Street, Boise, Idaho.

W. L. Macaulay, Marshfield, to 313 Oak Street, S. E., Minneapolis, Minnesota.

L. M. Lapham, Balsam Lake, to Whitehall.

Landers Finseth, Milwaukee, to Brandywine Sanatarium, Marshallton, Delaware.

J. T. Hotter, Wauwatosa, to 1810 Spruce Street, Philadelphia.

R. L. Johnson, Wauwatosa, to Arbuckle, California.

Alvin Nathan, Wauwatosa, to Cook County Hospital, Chicago, Illinois.

D. M. Pick, Milwaukee, to 342 South Ninth Street, West Bend.

R. K. Salter, Cadott, to Columbia Hospital Milwaukee.

R. K. Irvine, Manawa, to U. S. Veterans Administration Hospital, Coatesville, Pennsylvania.

W. L. Stranberg, West Allis, to 509 Elm Spring Avenue, Wauwatosa.

E. H. Dufour, Hayward, to 6527 West Highland Avenue, Chicago 31, Illinois.

G. E. Collentine, Jr., Philadelphia, Pennsylvania, to 5066 North Green Bay Road, Milwaukee.

J. C. Mankey, Wauwatosa, to 530 South Fairview, St. Paul, Minnesota.

D. H. Gatherum, Wood, to 3036 North Stowell, Milwaukee.

P. J. Reinsch, Madison, to RFD #2, Box 3460, Sacramento, California.

H. O. Caswell, Fort Atkinson, to 592 Phillips Avenue, Glen Ellyn, Illinois.

Abe Adland, Milwaukee, to 5737 Nicollet Avenue, Minneapolis, Minnesota.

E. George Nadeau, Jr., Green Bay to 7024 East Erd Street, Chicago, Illinois.

T. W. Dasler, Wisconsin Dells, to Lake Delton.

G. E. Lembert, Wauwatosa, to Vancouver Clinic, Vancouver, Washington.

C. B. Pope, Baraboo, to 636 Gage Avenue, El Monte, California.

Robin Smith, Neenah, to General Delivery, Brookfield.

DEATHS

Dr. John M. Hogan, 72, one of the founders of the Oshkosh Clinic in Oshkosh, died suddenly at his home in that city on November 19. He had practiced in Oshkosh since 1911.

Doctor Hogan was born in Westport on July 21, 1876. He graduated from Rush Medical College in 1902, following which he established a practice in Rhinelander. He moved to Oshkosh in 1911. One of the founders of the Oshkosh Clinic, he served as president of that institution a number of years ago. He was a former chief of staff of Mercy Hospital and at the time of his death was a member of its executive board. He was also a former medical director of Alexian Brothers Hospital. From 1943 to 1946 he served as medical director of the Wisconsin National Life Insurance Company of Oshkosh, having been assistant medical director prior to that.

The doctor was a member of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association.

Among the survivors are his wife, four daughters, and a son, Dr. J. M. Hogan, Jr.

Dr. Samuel Buchan, former practitioner at Racine, died at the home of his son, Dr. Edward Buchan, in Chicago on November 27. He was 98 years old.

Born in the town of Dover on May 23, 1850, he attended the University of Michigan and received his degree in medicine from Bellevue Medical College in 1876. Following graduation, he practiced in Union Grove for many years. Later he located in Racine, where he practiced until his retirement thirty years ago.

The doctor is survived by his son.

Dr. Irving B. Love, a school physician for the Milwaukee Health Department for twenty-five years, died at a Madison hospital following a sudden illness, on November 23. He was 52 years old.

A native of Milwaukee, Doctor Love was born on October 26, 1896. He attended Milwaukee State Teachers College and Marquette University School of Medicine, receiving his medical degree from the latter in 1922. Following internship at St. Mary's Hospital in Oshkosh, he established his practice in Milwaukee, which he continued until his death.

The doctor was on the staffs of St. Mary's Hospital, St. Rose's Orphan Asylum, and the Milwaukee Catholic Home for the Aged. He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving are his wife, two sons, and a daughter.

Dr. G. W. Brickbauer, 81, a practitioner in Wisconsin for more than fifty years, died at his home in New Holstein on October 24. He had been in active practice until his death.

Born in Sheboygan County, Doctor Brickbauer graduated from the Missouri Homeopathic College, St. Louis, Missouri, in 1885. He established his first practice in Elkhart Lake, where he served for a time as village president. In 1910 he moved to Plymouth, and in 1933, following nine years of practice in Sheboygan, he returned to that community. Prior to locating in New Holstein in 1944, he practiced at Hilbert. While in Plymouth, he helped to organize the Chamber of Commerce and was instrumental in the organization of Rocky Knoll Sanitarium. In 1926 he was director of the Sheboygan Chamber of Commerce, and the following two years he served as its president.

His survivors include his wife and a daughter.

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Activities of the Women's Auxiliary for Fall, 1948

Mrs. Hammond Honored

Our immediate past president, Mrs. A. W. Hammond of Beaver Dam, is now National Medical Auxiliary chairman for *Hygeia*. She has also recently been elected treasurer of the Wisconsin Public Health Council.

Brown—Kewaunee—Door

Officers elected for the Brown–Kewanee–Door Medical Auxiliary were as follows: president, Mrs. Louis Milson, Green Bay; president-elect, Mrs. Robert W. Burns, Allouez; first vice-president, Mrs. E. S. McNevins, Green Bay; second vice-president, Mrs. W. W. Ford, Green Bay; secretary, Mrs. E. R. Killeen, Green Bay; treasurer, Mrs. John R. Goelz, Allouez.

Dane

The Dane County Medical Auxiliary met for dessert luncheon at the home of Mrs. Anthony Curreri, Madison, for the October meeting. Assistant hostesses were Mmes. B. J. Brindley, N. A. Hill, Charles Crownhart, Walter Sullivan, and Carl Neupert. A speaker from the Madison Youth Council talked on the Community Chest drive.

Mrs. Walter Urben, Mendota, was hostess at a dessert luncheon on November 8. Following a tour of the Mendota State Hospital during the afternoon, a "white elephant" sale was held.

Dodge

Mrs. Merle Q. Howard of Milwaukee, state president of the Auxiliary to the State Medical Society, was honored guest at a supper meeting of the Dodge County Auxiliary at the home of Mrs. G. H. Hoyer, Beaver Dam, for the October meeting. Mrs. Mark Temkin presided, and Mrs. Howard spoke on the main objectives to be undertaken this year. A layette was presented to the county nurse for distribution.

Fond du Lac

Members of the Fond du Lac County Medical Auxiliary held a dinner session for their October meeting at the home of Mrs E. V. Smith, Jr. Assisting hostesses were Mmes. S. E. Gavin, J. S. Huebner, L. S. Simon, R. W. Schroeder, H. C. Werner and E. L. Watson. Mrs. Steube presided over the business meeting. The group voted to send holiday boxes to the 279th station hospital in Berlin, Germany, with the philanthropic committee in charge of the project, Mrs. H. J. Kief, chairman.

The November 18 meeting was a luncheon at the Children's Home.

Kenosha

The auxiliary to the Kenosha County Medical Society met on October 26 at the home of Mrs. Edgar Andre. It was decided to send the usual cash donations to the following hospitals for Christmas: Kenosha, St. Catherine's, Kenosha Isolation and Willowbrook Sanatorium. The members of the Kenosha County Medical Society were entertained by the Auxiliary at a buffet supper shortly before Christmas at the home of Mrs. Richard Block.

La Crosse

A highly effective panel discussion on ways of improving the mental health of a community was arranged and presented at a dinner meeting on November 10 by the Women's Auxiliary to the La-Crosse County Medical Society. Mrs. John Satory presided, and Mrs. Victor Bruder, program chairman introduced the speakers. They were: Esther H. de Weerdt, Ph.D., executive director of the Mental Health Society, Walter J. Urben, M.D. superintendent of Mendota State Hospital, and Harold Borenz, M.D., on the staff at Mendota. J. F. Rolfe, Ph.D., director of the division of elementary education and

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psychologist at the La Crosse State Teacher's College, was panel moderator and led a discussion period. About 150 persons attended, representing all organizations of the community, with school teachers, clergy, and parents also in attendance. Arrangements for the dinner were made by Mrs. C. L. Mears, social chairman.

Manitowoc

Officers for the ensuing year and plans for the year were presented in booklet form to the members of the Manitowoc County Auxiliary at the October meeting held at the home of Mrs. C. J. Skwor, Mishicot, with Mrs. L. J. Moriarty as co-hostess. The new officers are: Mrs. Norman C. Erdmann, re-elected president; Mrs. Lawrence W. Gregory, president-elect; and Mrs. William A. Rauch, secretary and treasurer. The Mishicot high school chorus presented the program.

On November 17 the auxiliary met at the home of Mrs. W. A. Rauch with Mrs. N. C. Erdmann as co-hostess. Mrs. Winifred MacVicar, the exchange teacher from London, was the speaker. A bake sale was held.

The December 15 meeting was a Christmas luncheon with Mrs. F. W. Hammond, Mrs. R. S. Simonson, and Mrs. Radl as hostesses. Mrs. Harry Pehrson presented a vocal program, with Mrs. C. A. Randolph as accompanist.

Columbia—Marquette—Adams

The Columbia–Marquette–Adams County Medical Auxiliary opened its meeting of the year with a dinner at the Portage Hotel the evening of October 12. The November 9 meeting was held at the Portage Hotel, where it was decided to make a collection of clothing for shipment overseas.

Milwaukee

The first meeting of the Milwaukee County Auxiliary was held November 12 at the College Women's Club. Dr. H. Kent Tenney, chairman of the state board of pediatrics was the speaker on "Preventative Aspects of Emotional Disturbances and Behavior Problems in Children." Doctor Tenney is also associate professor of pediatrics at the University of Wisconsin Medical School. Tea followed the meeting. Those who poured were Mrs. Merle Q. Howard, state president; Mrs. John S. Hirschboeck, wife of the dean of Marquette University School of Medicine; Mrs. L. J. Van Hecke, program chairman, and Mrs. J. O. Kelley, wife of the executive secretary of the Milwaukee County Medical Society.

A study club meeting was held October 27 when Dr. M. J. Fox spoke on "Poliomyelitis and the Doctor's Wife."

Polk

Indian Head Resort was the meeting place of the Polk County Auxiliary. Following dinner a business

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meeting was held, at which it was decided to place *Hygeia* in all Polk County beauty parlors. Mrs. H. C. Caldwell of Madison, a charter member, was present.

Racine

The Auxiliary to the Racine County Medical Society met October 25 at the home of Mrs. Robert Lehner. Election of officers took place, and Mr. Benjamin G. Lohr, principal of the Winslow School and a member of the board of directors of the Racine Welfare Department, discussed "Family Service," the work of the Racine Central Association.

Sauk

The Sauk County Auxiliary was entertained at a luncheon-bridge party in September by Mrs. E. L. Jewell in her home at Loganville.

On October 12 the Sauk County Nurse spoke at the Warren Hotel at Baraboo, and members voted to re-subscribe to *Hygeia* for all Sauk County state graded schools, the county old people's home, several high schools and a hospital.

After a luncheon in Sauk City, Mrs. George Chatterton, former National Parent Teacher president, spoke at the home of Mrs. Milton Trautmann, Prairie du Sac, on the work of the Youth Service Commmission, especially on the reorganization of the Wisconsin School for Boys at Waukesha. Mrs. Barbara Trachte, Madison, former craft teacher at Waukesha, told of her work with the boys, and later showed slides of Wisconsin scenes which she had taken, with appropriate poems. The Sauk County Auxiliary is adjourned until March.

Sheboygan

Sheboygan County Medical Auxiliary met for dessert-bridge at the home of the president, Mrs. L. M. Simonson, October 14.

On November 10 the Auxiliary met at the home of Mrs. J. F. Kovacic, Mrs. B. F. Eckardt assisting, for an afternoon of interpretations on books for good reading, by Mrs. Frank Stroub of Sheboygan Falls. All members donated packages for the gift shop at Wood Veteran's Hospital, and hostesses offered a surprise package, proceeds going into the CARE fund.

Mrs. W. G. Meier was chairman of a public discussion at Fellowship Hall on Tuesday evening, November 23, "On Civic Responsibility for Mental Health," sponsored by the Sheboygan County Medical Society, at which representatives of all women's organizations were present.

Walworth

The Walworth County Medical Auxiliary has renewed *Hygeia* subscriptions to all the rural schools in their county and purchased an electric portable phonograph for use in the rural schools.

Winnebago

A review of Philip Barry's play, "Tomorrow and Tomorrow" was read by Mrs. Glenn Hoffmann, high-

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lighting the opening meeting of the Winnebago County Auxiliary September 27 at the home of Mrs. G. R. Anderson. At the tea following, Mrs. R. H. Bitter and Mrs. E. F. Cummings, of Oshkosh, presided at the table. Hostesses, all from Menasha–Neenah were: Mesdames N. F. Pansch, G. R. Anderson, R. C. Brown, D. M. Regan, Fred Smith, and John R. Nebel.

"The Creation and Appreciation of Gems and their Artificial Substitutes" was discussed by Edwin E. Olson, Milwaukee jeweler, when he spoke to the Auxiliary at a luncheon meeting at Hotel Whiting, Berlin, October 25.

Mrs. Marvin Steen, Oshkosh, was hostess at her home for dessert-bridge on December 6.

AS IT LOOKS TO YOUR STATE BOARD OF HEALTH

(Continued from page 1187)

nually with Doctor Finke, city dentist, and the writer doing the examinations.

The third post-fluorination survey at Sheboygan has been completed in the kindergarten (5 to 6 years) and the fourth grade (9 to 10 years). This survey shows that in less than three years the decay rate (decayed, extracted, filled) for the kindergarten children has been reduced from 4.80 to 3.46—an improvement of 28 per cent. The decay rate for the fourth grade children has been reduced from a D.M.F. (decayed, missing, filled) rate of 3.03 to 2.44—an improvement of 19 per cent.

The great improvement in the dental health of the children of Sheboygan, as shown by these figures, positively demonstrates that the artificial fluorination of public water supplies will prevent dental caries just as effectively as natural fluorine water. The cost of fluorinating the city of Sheboygan water supply was 11 cents per capita last year.

It is now definitely known that the artificial fluorination of public water supplies "actually works" in the prevention of dental caries and that the cost is exceedingly small. Every community having a public water supply can reduce the dental decay in its oncoming generations 65 per cent by the simple and inexpensive process of fluorinating its public water supplies. A practical method of preventing dental caries is now available. It is plain to see that any community having a public water supply can eliminate two thirds of the dental decay in its young children and the generations to come.—F. A. BULL, D.D.S., M.S.P.H., *Director, Division of Dental Education.*

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The 1947 Year Book of Neurology, Psychiatry and Neurosurgery. Neurology edited by Hans H. Reese, M. D., Professor of Neurology and Psychiatry, University of Wisconsin Medical School; and Mabel G. Masten, M. D., Associate Professor of Neuropsychiatry, University of Wisconsin Medical School. Psychiatry edited by Nolan D. C. Lewis, M. D., Director New York State Psychiatric Institute and Hospital; Professor of Psychiatry, Columbia University. Neurosurgery edited by Percival Bailey, M. D., Professor of Neurology and Neurological Surgery, University of Illinois. Chicago: The Year Book Publishers, Inc., 1948. Price $3.75.

The 1947 Year Book of Neurology, Psychiatry, and Neurosurgery reflects the general postwar improvement in the caliber and scope of medical literature. Emphasis has been placed properly upon material of practical and clinical value. Especially is this true of the sections devoted to therapy. Again, as in previous years, critical editorial evaluation allows for a much better appreciation of the subject matter than would otherwise be possible. The volume is the best of those published since the war.—M. J. M.

Brief Psychotherapy. A Handbook for Physicians on the Clinical Aspects of Neuroses. By Bertrand S. Frohman, M. D. With the Collaboration of Evelyn P. Frohman. Foreward Walter C. Alvarez, M. D. Pp. 265. Philadelphia: Lea & Febiger, 1948. Price $4.00.

This book gives a brief, yet clear and understandable, description of the clinical aspects of the neuroses. It is carefully organized and well written. Intended for the general practitioner or non-psychiatric specialist, the material is refreshingly factual and practical with a minimum of theoretic considerations. It is well illustrated by numerous excellent case histories.

Approximately one half of the book is devoted to the presentation of the etiology, classification, diagnosis, and mechanisms of the neuroses. The remainder is devoted to psychotherapy. Although all types of therapy are discussed, emphasis is placed upon the brief, practical therapeutic procedures, which in the author's opinion and experience lend themselves best to the ordinary needs of the general practitioner. "Brief Psychotherapy" is an interesting and instructive book which should be of value to all practitioners who are called upon to treat the neuroses and psychosomatic disorders.—M. J. M.

Psychobiology and Psychiatry. A Textbook of Normal and Abnormal Human Behavior. By Wendell Muncie, M. D., Practicing Psychiatrist; Chairman, Medical Advisory Board, Seton Institute, Baltimore, Maryland; Associate Professor of Psychiatry, Johns Hopkins University; Consultant in Psychiatry, U. S. V. A. Second Edition. Pp. 620, with 70 illustrations. St. Louis, The C. V. Mosby Company, 1948. Price $9.00.

Stripped of its Meyerian language, "Psychobiology and Psychiatry" might be readable if not intelligible. Stated in simplest terms, Meyer's approach to the understanding of personality is by study of the whole person longitudinally, which includes knowledge of the stuff of which he is made, physical and mental; a study of his environment and his interpersonal relationships. In his evaluation of personality disturbances, Meyer and his disciples make use of all that has proved serviceable from other schools of psychology. The dynamics of thinking and behavior disturbance are interpreted in the light of the contributions of such scholars as Adler, Jung, and Freud. By all odds, Meyer's methods are most logical, most readily understood and adapted to the practice of medicine in general and psychiatry in particular. Unfortunately, Meyer has insisted on the use of euphonious words. This euphemism serves only to make less intelligible a part of medical science that more than any other calls for the best tools of the English language, words of simplicity.

Muncie has not succeeded in making his master entirely intelligible. His text is uninteresting and poorly organized and lacks fluidity. Many listings of pertinent data are used with deficient inadequate explanatory materials. The whole text is not well integrated.

Though this particular book cannot be wholeheartedly recommended to medical students as a

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study text; nevertheless it contains the theory and practice of Adolph Meyer and is not unintelligible to the specialist, merely uninteresting reading. It presents the most usable, teachable psychologic doctrine. If there be an American School of Psychiatry, this deservedly is it.—M. G. M.

Advances in Military Medicine. Made by American Investigators Working under the Sponsorship of the Committee on Medical Research. Edited by E. C. Andrus, D. W. Bronk, G. A. Carden, Jr., C. S. Keefer, J. S. Lockwood, J. T. Wearn, and M. C. Winternitz. Vols. I and II. Pp. 900. Boston: Little, Brown and Company, 1948. Price (2 vols.) $12.50.

Volume I

This book and a subsequent volume present a summary of the results obtained in the splendid cooperative effort in medical research conducted by the Office of Scientific Research and Development. Much that was discovered was in the nature of furthering our knowledge of fundamental physiology of such conditions as shock or starvation, the effects of anoxia, acceleration, high altitudes, etc.

The contributions in the field of infectious diseases are numerous and include not only new methods of prophylaxis, diagnosis, and treatment but also further information about the life cycles of bacteria and other pathogens.

The "Medical Problems of Convalescence" is an interesting chapter and includes studies of protein metabolism, anemia, and the cardiovascular system as well as the psychiatric aspects.

A section on surgery describes new surgical plastics and hemostatics and revised attitudes in the treatment of wounds, burns, peripheral nerve injuries, and trench foot.

Aviation medicine has many unique problems attendant upon the physiologic stress occasioned by the tremendous speed and changes in atmospheric pressure and temperature which are part of modern air combat. The study of these problems has furthered fundamental physiologic knowledge and is a fascinating chapter in this book.—E. G.

Volume II

This book is the second volume of the report on medical research conducted by the Office of Scientific Research and Development. The rather extensive work on nutrition emphasizes again the uselessness of much of the excessive vitamin supplements used commonly in medical practice today. The study on ascorbic acid at Northwestern University suggested, contrary to the opinion of many authorities, that a decrease in plasma ascorbic acid levels was the best early sign of an inadequate dietary intake.

Tolerance to heat and cold and the effect on acclimatization of variations in diet, vitamin intake, and clothing was studied in detail.

The research in chemical warfare revealed many clinically important and now familiar drugs such as nitrogen mustard, B.A.L., D.D.T., and the rodenticide A.N.T.U.

The search for new antimalarial drugs, intensified by the abrupt cutting off of the quinine supply in 1941, uncovered several interesting new observations on the biology and biochemistry of the malarial parasite and a new combination of an 8 amino quinoline and quinine which is apparently curative.

The importance of the development of penicillin need not be commented on, but the rapidity of its development is a tribute to an almost unequaled cooperative effort on the part of both England and the United States.

A chapter on sensory devices stimulates one's imagination as to the possibilities on utilization of supersonic waves by the blind for the detection of objects.

A complete bibliography concludes this second volume.—E. G.

Diabetes Mellitus in General Practice. By Arthur R. Colwell, M. D., Associate Professor of Medicine and Director of Medical Specialty Training, Northwestern University Medical School; Attending Physician, Evanston Hospital, Evanston, Illinois; Consulting Physician, Wesley Memorial Hospital, Chicago. Pp. 350. Chicago: The Year Book Publishers, 1947. Price $5.25.

This is a very excellent condensation of the essential facts required by the practitioner in the intelligent management of diabetes mellitus. The presentation is clear, orderly, and logical. The material is confined to accepted fact and yet is not dogmatic. Controversial points are discussed, the pros and cons summarized and the reader allowed to draw his own conclusion. The result is a sensible and refreshing review of the subject.

Diagnostic criteria and practical methods are given in detail, together with useful tables concerning the classification of diabetes according to severity with characteristics and suggested management for each. A useful and complete summary of conditions associated with melituria is given. The advantages and objectives of treatment are given. In this connection the author makes a strong argument in favor of close control of hyperglycemia and glycosuria. This provides a welcome rebuttal to the proponents of "laissez faire" management of diabetes. Criteria for diabetes manageable by diet alone are given in connection with ample information on how to select and prescribe a balanced diet for the individual patient. The various types of insulin are discussed with the aid of excellent graphs illustrating the intensity and duration of hypoglycemic effect obtained with each type and with mixtures. The indications for each and the use of insulin in treatment are well presented. Especially helpful are the two chapters dealing with the management of acute and chronic complications. Full instructions are given for the treatment of acidosis, for control at time of surgery and in the presence of acute infections. The increasingly common and disturbing vascular complications are reviewed briefly. Treatment of diabetes during pregnancy is well covered.

The excellent bibliographies at the end of each chapter are helpful for further reference.—E. C. A.

Hygeia

THE HEALTH MAGAZINE

NOVEMBER 1948 35¢

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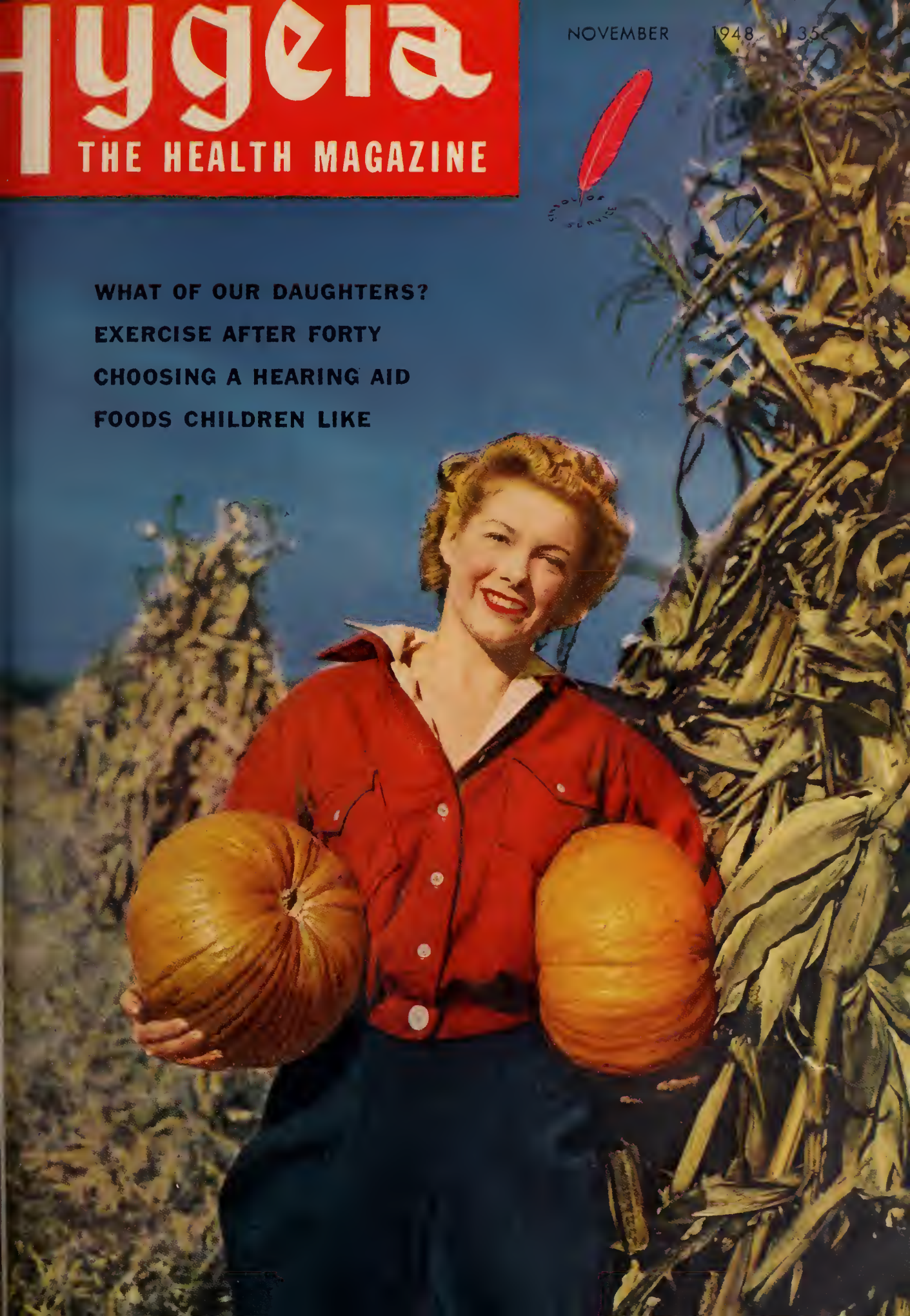

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COMING EVENTS

American Board of Obstetrics and Gynecology, Inc., Announces Examination Date

The next written examination and review of case histories (Part I) for all candidates for the American Board of Obstetrics and Gynecology will be held in various cities of the United States and Canada, February 4, 1949.

Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Those who successfully complete Part I proceed automatically to Part II, to be held May 8–14, 1949 at the Hotel Shoreland, Chicago. Notice of the exact time and place of the examinations will be sent all candidates well in advance of the examination date.

New bulletins are now available for distribution upon application and give details of all changes in requirements and regulations of the Board which were made at its annual meeting in Washington, D. C., May 16–22, 1948. These relate both to candidates and to hospitals conducting residency services for training.

Application forms and bulletins are sent upon request to American Board of Obstetrics and Gynecology, Inc., 1015 Highland Building, Pittsburgh 6, Pennsylvania.

American College of Surgeons Announces 1949 Sectional Meeting Schedule

The American College of Surgeons has announced that six two-day sectional meetings have been scheduled between January 7 and April 13, 1949 for physicians and professional personnel of hospitals. A seventh meeting, to be held in the West late in April, will be definitely scheduled later. The latest developments in medical science and hospital service will be presented at each meeting.

The sessions will be held as follows: January 7–8, Edgewater Park, Mississippi; January 14–15, Houston, Texas; February 11–12, Kansas City, Missouri; March 15–16, Washington, D. C.; March 21–22, Buffalo, New York; and April 12–13, Edmonton, Alberta, Canada.

Conferences for the hospital personnel and for the medical groups will run concurrently. A joint meeting of the two groups will open at 8:30 a. m.

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each day, with the showing of medical motion pictures, to be followed at 10 a. m. by separate sessions. A dinner meeting followed by a round-table conference will be held on the first evening.

Chicago Medical Society to Hold Annual Conference

The fifth annual clinical conference of the Chicago Medical Society will be held at the Palmer House in Chicago, March 1–4, 1949. The scientific program will be presented by well known speakers from all sections of the country, who will discuss subjects of interest to all physicians. One of the features of the conference will be the luncheon round tables, when questions will be answered by the speakers. Scientific and technical exhibits have also been planned.

Physicians from other states and cities are invited to attend this medical conference. Reservations should be made directly with the Palmer House.

University of Minnesota Medical School Schedules Postgraduate Courses

A one week course in ophthalmology will be given at the Center for Continuation Study by the University of Minnesota Medical School the week of January 24–29, 1949. The course is designed particularly for ophthalmologists.

The presentation of a three day course in obstetrics for general physicians has been scheduled by the medical school January 6–8. This will also be given at the Center for Continuation Study.

A continuation course in Cardiovascular Diseases will be given at the Center for Continuation Study on February 14 and 15. The course is intended for general physicians and is sponsored by the Minnesota Heart Association.

On February 7–9 the University of Minnesota will present a continuation course in pediatrics at the Center for Continuation Study. This course is intended for general physicians and is sponsored by the Minnesota Department of Health.

Dr. O. G. Moland to Speak at Medical School Convocation

Dr. O. G. Moland, Augusta, will be the guest speaker at a convocation of the University of Wisconsin Medical School on January 12 in the auditorium of the Service Memorial Institutes Building. Doctor Moland, who is a graduate of the university medical school, has chosen "From the View Point of the Country Physician" as his subject. Medical students will be dismissed from their classes at 4 p. m. in order to attend the convocation.

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Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

WANTED: General practitioner to take over large practice of doctor who is retiring. Territory is in urgent need of a physician. Address replies to No. 169 in care of the Journal.

WANTED: A combination physiotherapist and x-ray technician for a physician and surgeon's office in Waukesha. Please state age, experience, salary, and availability. Address replies to No. 184 in care of the Journal.

YOUNG MAN WANTED: Physician with large practice in thriving college town in southern Wisconsin desires young associate. Good salary and assured living quarters. Exceptional opportunity for man with sound basic training. Address replies to No. 144 in care of the Journal.

FOR SALE: Country practice in northwest Wisconsin. No competition. Modern residence, ideally located. Annual dairy income in territory. Nothing to buy but five bedroom residence, with office room, waiting room, and laboratory in residence. Separate parking and sidewalk to waiting room. Spacious lawn, foliage, and ideal residence. Young man can use extra rooms for hospital rooms. Selling reason: coronary thrombosis. Address replies to No. 170 in care of the Journal.

FOR SALE: Well equipped E. E. N. T. office. Proximate value, $1,500. First $500 takes all. This includes small edging machine with diamond cutter and drill. Portable ether and suction machine and diathermy perimeter, everything needed for work. Address replies to No. 196 in care of the Journal.

WANTED: E. E. N. T. man to take over practice for months of January, February, and March 1949. Address replies to No. 201 in care of the Journal.

FOR SALE: A medical examining table, oak, 30" high, dimensions 24 x 50". Padded leather top with extension leg and arm rest. Address replies to No. 188 in care of the Journal.

FOR SALE: Library of late physician, containing approximately 70 volumes. Also microscope, stethoscope, and other equipment available. Address replies to No. 189 in care of the Journal.

WANTED: Associate in general practice, preferably one who has just finished internship or one year as resident physician. Address replies to No. 192 in care of the Journal.

WANTED: A doctor for a lucrative practice in a prosperous dairy community. Give all qualifications—age, experience, nationality, single or family—with first inquiry. Address replies to No. 141 in care of the Journal.

FOR RENT: Four room office with oil heat, at street level in cement block building. Located near Madison. Address replies to No. 200 in care of the Journal.

WANTED: Associate for practice in South Texas. Good climate. Associate should net $800 plus per month. Should be available by January 1, 1949. Family man preferred. Address replies to No. 202 in care of the Journal.

FOR SALE: General practice and office building, including x-ray and equipment, also complete stock of drugs. Located in central Wisconsin. Large farming area. Doctor passed away recently. Address replies to No. 204 in care of the Journal.

FOR SALE: Portable General Electric X-Ray unit, also Fischer Mobile 30 ma. shockproof x-ray unit in excellent condition. Several used Fischer short-wave diathermy units and one new floor demonstrator priced reasonably. Also available, slightly used hyfrecator, whirlpool bath, Jones metabolism unit, ultra-violet lamp, and x-ray table with Bucky. Address replies to C. C. Remington, 720 North Jefferson Street, Milwaukee 2, Wisconsin or call Daly 8–6368.

WANTED: Young physician as an associate in a very lucrative practice in the Fox River Valley area. Address replies to No. 203 in care of the Journal.

LOCATION WANTED: By Norwegian physician and surgeon in city of 5,000 or over. Partnership or industrial work considered. Address replies to No. 206 in care of the Journal.

FOR SALE: General practice in central Wisconsin city of 30,000; also equipment and instruments, including Hamilton Nu-Tone examining table, diathermy, Birtches nyfucator, sterilizer, etc. Office space and living quarters available. Ideal for young man who wishes to begin independent practice with minimal investment and assured income from the start. Address replies to No. 207 in care of the Journal.

LOCATION WANTED: Obstetrician-gynecologist, veteran, married, now completing his third year of AMA-approved residency and meeting the requirements of the OB–GYN Board, will be available in Spring for an association with Board diplomate or possibly group or clinic. Address replies to No. 209 in care of the Journal.

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YOUNG PHYSICIAN WANTED: To associate with general practitioner, age 30, in northwestern Wisconsin city of 4,000. Give all qualifications, experience, age, nationality, single or family, with first inquiry. Address replies to No. 210 in care of the Journal.

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WANTED TO BUY: Second hand examining table, good condition. Address replies to No. 213 in care of the Journal.

OPPORTUNITY: Clinic in western Wisconsin desires services of young man capable of doing general surgery. Good salary assured. Write No. 214 in care of the Journal.

The Mendota State Hospital is in need of nurses and doctors. Advanced training in psychiatry is desirable but not necessary. These positions are all permanent and are under Civil Service. If interested, write or contact W. J. Urben, M. D., superintendent of Mendota State Hospital.

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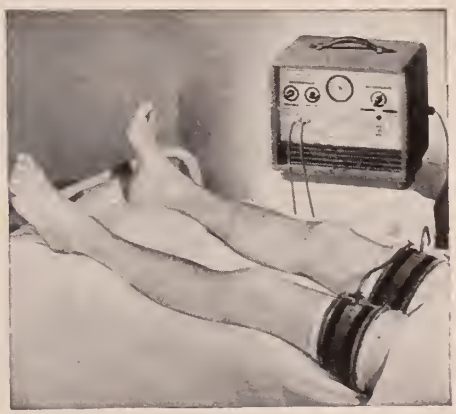

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	1155
Audiphone Utilities	1255
Ayerst, McKenna & Harrison	1150
Barr X-Ray Co.	1252
Bellevue Place	1255
Benson Optical Co.	1267
Bergmann Prescription Pharmacy	1235
Camel (R. J. Reynolds Tobacco Co.)	1151
Camp, S. H. & Co.	1160
Central Drug	1246
Chicago Medical Society	1148
Ciba	1239
Coca Cola Co.	1244
Cook County Graduate School of Medicine	1256
Doerflinger's	1255
Endocrine Laboratories	1255
First Central Dispensary	1235
Hotel Schroeder	1149
House of Bidwell, Inc.	1252
Hurley X-Ray Co.	1255
Ivanhoe Treatment, Inc.	1267
Jensen Brothers	1246
Kennedy–Mansfield Dairy	1254
Lilly, Eli and Company	facing page 1163
Lov-é Brassieres	1237
M & R Dietetic Laboratories, Inc.	1152
Mallatt Pharmacy	1235
Mather Pharmacy	1246
Mayer Drug	1246
Mead Johnson & Co.	1157, 1266
Medical Protective Co.	1156
Merck & Co., Inc.	1233
Milwaukee Optical Co.	1247
Milwaukee Sanitarium	1268
New World Life Insurance Co.	1241
New York Polyclinic	1253
Orthopedic Appliance Co., Inc.	1255
Parke, Davis & Co.	1146, 1147
Physicians Casualty Assn.	1256
Physicians Radium Assn.	1149
Pogue, Mary E., School	1253
Prescription Pharmacy	1235
Professional Business Service	*Forum* 5
Rennebohm Drug Stores	1235
Rentschler Floral Co.	1254
Roemer's	1252
Rogers Memorial Sanitarium	1268
Sacred Heart Sanitarium	1241
St. Croixdale Sanitarium	1149
Schering Corporation	1159
Schlintz Bros. Drug Store	1246
Searle, G. D. & Co.	1231
Shorewood Hospital Sanitarium	1235
Smith–Dorsey Company	1162
Smith, Kline and French	1153
Spencer, Inc.	1245
Summit Hospital	1247
Swift and Company	1243
Time Insurance Company	*Forum* 3
Wander Co.	1154
Winthrop–Stearns, Inc.	1161
Wyeth, Inc.	1158

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INDEX

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VOLUME XLVII
JANUARY, 1948—DECEMBER, 1948

INDEX VOL. XLVII, 1948

SCIENTIFIC ARTICLES

Page

Abortion, Hyperemia Pregnancy Test in Threatened, Pessin ---------- 876
Acute Cholecystitis, Management of, Zollinger ---------- 472
Acute Infectious Disease in Children, Therapy in, Conway ---------- 395
Acute Intestinal Obstruction in the Patient over 60 Years, Haley and Jackson ---------1180
Acute Obstructive Cholecystitis, Kiernan ---------- 776
Addison's Disease, The "Water Test" in, Pessin ---------- 783
Allergic Child, The Management of the, Lee ---------- 204
Amebiasis, The Laboratory Diagnosis of, Birge ---------1104
Amino Acid Utilization, Protein and, Hibma ---------- 590
Anesthesia and Liver Function, Pohle ---------- 476
Anesthesia and Surgery, Evaluation and Management of the Cardiac Patient for, Rosenbaum ---------- 989
Anesthesia and Surgical Procedures, Evaluation of the Cardiac Patient for, Meyer - 987
Anesthesiology for Wisconsin, Kreul ----------1081
Antibiotic Effective in the Treatment of Rickettsial Diseases, An, Tatum ---------- 697
Antibiotics in Ear, Nose, and Throat, Salinger ---------- 997
"Antihistaminic," Drugs, The, Orth ----------1002
Appendicitis in Rock County, Research Project on, Snodgrass, Munn, and Flarity -- 388
Appendix, Diverticulosis and Diverticulitis of the, Frye and Miale ---------- 868

Bacterial Endocarditis with Penicillin and with Streptomycin, The Treatment of Subacute, McCoy and Meyer 671
B.A.L. and Peritoneal Irrigation, The Treatment of Mercury Poisoning with, Longley ----------1081
Benign Multiple Hemangiomas, King, Klieger, and Weinshel ----------1095
Birth, Infant Death, and Stillbirth Data, Wisconsin 1947, Hunter ---------- 870
Bladder Tumors; Their Diagnosis, Treatment, and Prognosis, Sargent ----------1166
Bone Tumors, The Treatment of Metastatic, Smedal and Salzman ---------- 675
Brain Tumors, Practical Aspects of Diagnosing, Quade 583
Bronchogenic Carcinoma; The Cytologic Diagnosis from Bronchial Aspirations and Sputum, Swan ----------1092
Bronchopulmonary Segments and Variations in Pulmonary Vascular Patterns, Appleton ----------1185
Brucellosis, Treatment of, Tatum ---------- 780
Bulbar Poliomyelitis, Tatum-- 875
Bulbar Poliomyelitis, Some Modern Aspects in the Treatment of, Bouman and McDonough ----------1099

Carcinoma, Bronchogenic, The Cytologic Diagnosis from Bronchial Aspirations and Sputum, Swan ----------1092
Carcinoma and Inflammatory Disease of the Lung, Present Status of Pulmonary Resection for, Gale and Curreri -- 210
Carcinoma of the Cervix, The Treatment of, Cron ---------- 480
Carcinoma of the Common Bile Duct; Report of a Case, with Discussion, Killins ---------- 859
Cardiac Function Test Based on Anoxia Induced by Rebreathing Air, Holbrook and Shapiro ---------- 571
Cardiac Patient for Anesthesia and Surgery, Evaluation and Management of the, Rosenbaum ---------- 989
Cardiac Patient for Anesthesia and Surgical Procedures, Evaluation of the, Meyer --- 987
Cephalin–Cholesterol Flocculation Test, the Thymol Turbidity Test, and the Thymol Flocculation Test, the, Jaeschke ---------- 307, 406
Cervix, The Treatment of Carcinoma of the, Cron ---------- 480
Child Development, Focal Points in, Senn ---------- 861
Child, The Management of the Allergic, Lee ---------- 204
Cholecystitis, Acute Obstructive, Kiernan ---------- 776
Cholecystitis, Management of Acute, Zollinger ---------- 472
Chronic Hepatic Disease, Notes on the Treatment of, Snell -- 199
Cirrhosis, Dietary Treatment of Hepatic, Sims ----------1103
Comments on Treatment ---------- 214, 306, 399 483, 602, 697, 780, 875, 1002, 1103
Common Bile Duct, Carcinoma of the; Report of a Case, with Discussion, Killins ---- 859
"Connell Suture," The So-Called, Connell ---------- 599
Cyclodialysis and Iridectomy for Glaucoma with Cataract, Copps ---------- 469

Diabetes Mellitus, Objectives in the Management of Children with, Jackson ---------- 587
Diabetic Patient, The Management of the Surgical, Baldwin ----------1177
Dietary Treatment of Hepatic Cirrhosis, Sims ----------1103
Digitalis Preparation, Choice of a, Beckman ---------- 483
Diuretic, Oral Administration of a Mercurial, Beckman --- 602
Diverticula, Duodenal, McRoberts ---------- 994
Diverticulitis of the Appendix, Diverticulosis and, Frye and Miale ---------- 868
Diverticulosis and Diverticulitis of the Appendix, Frye and Miale ---------- 868
Duodenal Diverticula, McRoberts ---------- 994

Edema, The Clinical Management of, Pohle and McKittrick --- 294
Embolism, Therapy of Pulmonary, Beckman ---------- 399
Endocarditis with Penicillin and with Streptomycin, The Treatment of Subacute Bacterial, McCoy and Meyer --- 671
Epilepsy, Therapy in, Merritt 463

Face Pains, Headaches and Head and, Frawley ---------- 773
Feeding, Trends in Infant, Senn ---------- 195
Fluorination of Public Water Supplies Proves Its Value, Bull ----------1187
Focal Points in Child Development, Senn ---------- 861
Fracture Disabilities, Jones -- 207

Gastrointestinal Examinations, An Outline of Procedure for Routine Roentgenologic, Sherman ---------- 296
General Physician, Psychiatry and the, Hastings ---------- 379
Generalized Scleroderma; Report of a Case, Ries ---------- 299
Glaucoma with Cataract, Cyclodialysis and Iridectomy for, Copps ---------- 496
Glomerulonephritis, The Management of the Nephrotic Syndrome in Chronic, Hilker 693
Graft, Reconstruction of a New Thumb by Tubular Pedicle and Bone Cartilage, Hardin 763

Head and Face Pains, Headaches and, Frawley ------ 773
Headache, Histamine in Certain Types of, Salinger ----- 362
Headaches and Head and Face Pains, Frawley ---------- 773
Hemangiomas, Benign Multiple, King, Klieger, and Weinshel ----------1095
Hemorrhages of Pregnancy, Management of Late, Bloomfield ---------- 287
Hepatic Cirrhosis, Dietary Treatment of, Sims ---------1103
Hepatic Disease, Notes on the Treatment of Chronic, Snell 199
Hepatitis, Prevention of Syringe-Induced Infections, Lubitz ----------1186
Hepatitis, Therapy of Infectious, Beckman ---------- 306
Hernia in a Man 88, Operation and Recovery, Strangulated Inguinal, Falk ----------1172
Histamine in Certain Types of Headache, Salinger --------- 382
Hyperemia Pregnancy Test in Threatened Abortion, Pessin 876
Infant Death, and Stillbirth Data, Birth, Wisconsin 1947, Hunter ---------- 870
Infant Feeding, Trends in, Senn ---------- 195
Infantile Paralysis During the Acute Stage, The Treatment of, Lewin ---------- 769

Infectious Disease in Children, Therapy in Acute, Conway -- 395
Infectious Hepatitis, Therapy of, Beckman ---------- 306
Inguinal Hernia in a Man 88, Operation and Recovery, Strangulated, Falk ---------1172
Inflammatory Disease of the Lung, Present Status of Pulmonary Resection for Carcinoma and, Gale and Curreri ---------- 210
Intestinal Obstruction in the Patient over 60 Years; Review of 80 Cases, Haley and Jackson ----------1180
Iridectomy for Glaucoma with Cataract, Cyclodialysis and, Copps ---------- 469

Labor, A Symposium on Prolonged, Bloomfield ---------- 999
Leukemoid Reactions of the Myeloid Type, Jaeschke ----1010
Liver Function, Anesthesia and, Pohle ---------- 476

SCIENTIFIC ARTICLES—Continued

Page

Mercurial Diuretic, Oral Administration of a, Beckman 602
Mercury Poisoning with B.A.L. and Peritoneal Irrigation, The Treatment of, Longley 1089
Metastatic Bone Tumors, The Treatment of, Smedal and Salzman 675
Myeloid Type, Leukemoid Reactions of the, Jaeschke 1010

Nephrotic Syndrome in Chronic Glomerulonephritis, The Management of the, Hilker 693
Nitroglycerine, Treatment of Raynaud's Disease with, Fox and Leslie 855
Notes on Clinical Pathology 218, 307, 406, 484, 603, 698, 783, 876, 1010, 1104, 1186

Obstetrics, Serology and, LaVake 690
Occupational Medicine, Past and Present; As It Concerns Management, the Worker, and the Medical Department, Doctor, and Nurse Alike, Belknap 594

Penicillin Reactions, Beckman 214
Peripheral Vascular Disease, Experiences with Sympathectomy in, Sullivan and Ross 1083
Pin Worm Infections, Laboratory Diagnosis of, Nichols 218
Placenta Accreta, Urdan and Kurzon 1174
Poliomyelitis, Bulbar, Tatum 875
Poliomyelitis, Some Modern Aspects of the Treatment of Bulbar, Bauman and McDonough 1099
Pregnancy, Management of Late Hemorrhages of, Bloomfield 287
Pregnancy Test in Threatened Abortion, Hyperemia, Pessin 876
Prenatal Rh Testing, Ritchie 484
Prevention of Syringe-Induced Infectious Hepatitis, Lubitz 1186
Prolonged Labor, A Symposium, on, Bloomfield 999
Protein and Amino Acid Utilization, Hibma 590
Psychiatry and the General Physician, Hastings 379

Page

Psychosomatic Aspects of Thyrotoxicosis, Musser 291
Pulmonary Embolism, Therapy of, Beckman 399
Pulmonary Resection for Carcinoma and Inflammatory Diseases of the Lung, Present Status of, Gale and Curreri 210
Pulmonary Vascular Patterns, Bronchopulmonary Segments and Variation in, Appleton 1185

Raynaud's Disease with Nitroglycerine, Treatment of, Fox and Leslie 855
Retinal Detachment, Some Thoughts on the Surgery of, Vail 687
Rh Testing, Prenatal, Ritchie 484
Rheumatic Fever, Early Schizophrenia Complicated by, Veit 865
Rickettsial Diseases, An Antibiotic Effective in the Treatment of, Tatum 697
Ringworm of the Scalp; Review of 100 Cases, Ruch 385
Rock County, Research Project on Appendicitis in, Snodgrass, Munn, and Flarity 388
Roentgenologic Gastrointestinal Examinations, An Outline of Procedure for Routine, Sherman 296

Scalp, Ringworm of the; Review of 100 Cases, Ruch 385
Schizophrenia Complicated by Rheumatic Fever, Early, Veit 865
Scleroderma, Generalized; Report of a Case, Ries 299
Serologic Tests for Syphilis, Birge 603, 698
Serology and Obstetrics, LaVake 690
Stevens–Johnson Syndrome, Rosenberg 766
Stillbirth Data, Birth, Infant Death, Wisconsin 1947, Hunter 870
Strangulated Inguinal Hernia in a Man 88, Operation and Recovery, Falk 1172
Subacute Bacterial Endocarditis with Penicillin and with Streptomycin, The Treatment of, McCoy and Meyer 671

Page

Surgery, Evaluation and Management of the Cardiac Patient for Anesthesia and, Rosenbaum 989
Surgery of Retinal Detachment, Some Thoughts on the, Vail 687
Surgical Diabetic Patient, The Management of the, Baldwin 1177
Surgical Procedures, Evaluation of the Cardiac Patient for Anesthesia and, Meyer 987
Suture, The So-Called "Connell," Connell 599
Syphilis, Serologic Tests for, Birge 603, 698
Sympathectomy in Peripheral Vascular Disease, Experiences with, Sullivan and Ross 1083

Therapy in Epilepsy, Merritt 463
Thumb by Tubular Pedicle and Bone Cartilage Graft, Reconstruction of a New, Hardin 763
Tumors, Bladder; Their Diagnosis, Treatment, and Prognosis, Sargent 1166
Tumors, Practical Aspects of Diagnosing Brain, Quade 583
Tumors, The Treatment of Metastatic Bone, Smedal and Salzman 675
Thymol Flocculation Test, The Cephalin – Cholesterol Flocculation Test, the Thymol Turbidity Test, and the, Jaeschke 307, 406
Thymol Turbidity Test, and the Thymol Flocculation Test, The Cephalin – Cholesterol Flocculation Test, Jaeschke 307, 406
Thyrotoxicosis, Some Psychosomatic Aspects of, Musser 291

Vascular Disease, Experiences with Sympathectomy in Peripheral, Sullivan and Ross 1083

Water Supplies Proves Its Value, Fluorination of, Bull 1187
"Water Test" in Addison's Disease, The, Pessin 783

SPECIAL ARTICLES

Abortion, Criminal 64
Agreement on Panel Practice 76
American Medical Association Medical Ethics, Principles of 149
Membership and Fellowship Defined 110
Officers 154
Annual Dinner Address, President's 1163
American Society of Anesthesiologists, As It Looks from 608
As It Looks from the American Society of Anesthesiologists 608
As It Looks from the Blue Cross Viewpoint 401
As It Looks from the Committee on Nursing Education of the American Medical Association 308
As It Looks from the Committee on Rural Medical Service of the American Medical Association 700
As It Looks from the County Judge's Office 1014
As It Looks from the Wisconsin Public Health Council 1192
As It Looks from the Wisconsin State Chamber of Commerce 786
As It Looks from the Wisconsin Veterans Medical Service Agency 486
As Seen from the Countryside 1106
Autopsy 62, 82

Basic Science Law Enforcement 57
General 46
Blue Cross Viewpoint, As It Looks from the 401
Board of Health, Services, Laws, and Rulings, State 113

Cancer Form Provided, Important New 220
Child, Care of the Illegitimate 90
Chiropody 51
Chiropractic 52
Collection of Accounts, Outline of Laws Governing 92
Compensation Act, Workmen's 69
Cooperative Health Associations Enabling Act 58
Coroners 82
Countryside, As Seen from the 1106
County Judge's Office, As It Looks from 1014

Dangerous Drugs, Sale of Regulated 87
Davis, Mary Byard 618
Dead Lines 158
Deaths, Registration of 45
Diagnostic Services, Community 119
Diseases Reporting of 113
Doctor, Use of Title 56

Estate Tax 39
Externes, Legal Status 67

Federal Tax Deductions for Medical Care 103
Fee Splitting 60
Foreign Physicians, Statement by State Board of Medical Examiners on Licensing 1229

G. I. Bill of Rights 96
Gift Tax 39

Health, State Services, Laws, and Rulings 113
Hospital Construction Program 66
Hospital Records, Access to 108
Identification by Blood Test 112
Illegitimacy 90
Income Tax Provisions Affecting the Medical Profession
Federal 1193
State 1202
Inheritance Tax 39
Inquests 82
Internes, Legal Status 67
Jury Duty, Physicians Exemption from 89

Leases, Office 43
Licensure to Treat the Sick, Limitations of 56
Life Insurance, National Service 104
Liquor Prescriptions and Their Abuse 83
Loans and Grants for Veteran Doctors 106

SPECIAL ARTICLES—Continued

Malpractice ---- 61
Marijuana ---- 85
Marriage Laws ---- 88
Massage and Hydrotherapy--52, 57
Medical Ethics, Principles of - 149
Medical Practice Act, Enforcement ---- 46
Midwifery ---- 51, 57
Miscarriage, Criminal ---- 64

Naprapaths ---- 48
Narcotics
  Administering, Dispensing, Prescribing ---- 84
  Federal Law ---- 84
  Marijuana ---- 85
  Penalties ---- 85
  Purchase of ---- 86
  Registration, Narcotics, and Marijuana ---- 86
  Wisconsin Law ---- 84
Naturopaths ---- 48
Nursing Education of the American Medical Association, As It Looks from the Committee on ---- 308

Office
  See "Leases, Office"
Officers, State Board and Commissions ---- 128
Optometrists ----53, 57
Osteopaths ----50, 56

Panel Practice, Agreement on 76
Physicians and the Pharmacy Law ---- 107
Postmortem ----62, 82
Premarital Examinations ---- 88
President's Annual Dinner Address ----1163

Reciprocity Licensure Rules-- 68
Registration of Deaths ---- 45
Residents, Legal Status ---- 67
Respirators, Location of ---- 164
Rural Medical Service of the American Medical Association, As It Looks from the Committee on ---- 700

Sick, Treating in Wisconsin Basic Science Law ---- 46
  Chiropody ---- 51
  Chiropractic ---- 52
  Educational and Other Requirements ---- 54
  Licensure
    General Requirements ---- 47
    Limitations ---- 56
  Massage and Hydrotherapy 52
  Medicine and Surgery ---- 48
  Midwifery ---- 51
  Optometry ---- 53
  Osteopathy and Surgery ---- 50
State Health Services, Laws, and Rulings ---- 113
State Boards and Commissions, Officers of ---- 122
Sterilization ---- 65
Tax
  Estate ---- 39
  Gift ---- 39
  Inheritance ---- 39
  Marijuana ---- 86
  Narcotics ---- 86
Testimony
  Medical Witnesses and Expert ---- 77
  Privileged Status of Physicians in Legal Proceedings 80
Treating the Sick in Wisconsin 46
Tuberculous, Laws and Rules for the ---- 120
Tumor Clinic Opens at the State of Wisconsin General Hospital, March 15, 1948 ---- 313

Veterans, Record of Service Rendered to ---- 160
Vital Statistics ---- 117

Wisconsin General Hospital Law ---- 111
Wisconsin Public Health Council, As It Looks from the ----1192
Wisconsin State Chamber of Commerce, As It Looks from the ---- 786
Wisconsin Veterans Medical Service Agency ---- 97
Wisconsin Veterans Medical Service Agency, As It Looks from the ---- 486
Workmen's Compensation Act 69

AUTHORS

Appleton, Arthur B., London, England ----1185
Baldwin, Robert S., Marshfield ----1177
Bardwell, R. W., Madison ----1192
Beckman, Harry, Milwaukee -- ---- 214, 306, 399, 483, 602
Belknap, Elston L., Milwaukee 594
Birge, E. A. II, Milwaukee -- ---- 603, 698, 1104
Bloomfield, James H., Chicago ---- 287, 999
Bouman, H. D., Madison ----1099
Brehm, P. A., Madison ---- 219
Bull, F. A., Madison ----1187
Cameron, Eugenia S., Madison 312
Chisholm, G. Brock, Geneva, Switzerland ----1017
Connell, F. Gregory, Oshkosh 599
Conway, J. P., Milwaukee ---- 395
Copps, Lyman A., Marshfield -- 469
Cron, Roland S., Milwaukee -- 480
Curreri, A. R., Madison ---- 210
Doege, K. H., Marshfield ---- ---- 1079, 1107, 1189
Doran, T. J., Madison ---- 486
Elvehjem, Conrad A., Madison 1109
Falk, V. S. Jr., Edgerton ----1172
Fishbein, Morris, Chicago ----1019
Flarity, Thomas, Beloit ---- 388
Fox, Max J., Milwaukee ---- 855
Frawley, W. J., Appleton ---- 773
Frye, J. W., Milwaukee ---- 868
Gale, J. W., Madison ---- 210
Griffith, J. C., Milwaukee ---- 703
Grimm, Jay H., River Falls -- 1014
Haley, Harold B., Fort F. E. Warren, Wyoming ----1180
Hardin, Creighton A., Kansas City, Kansas ---- 764
Hastings, D. W., Minneapolis-- 379
Hibma, Otto V., Madison ---- 590
Hilker, A. W., Eau Claire ---- 693
Hirschboeck, John S., Milwaukee ---- 310
Holbrook, Arthur Andrews, Milwaukee ---- 571
Hunt, John H., Chicago ---- 608
Hunter, Amy Louise, Madison 870
Jacobsen, Oscar T., Racine --- 404
Jackson, Arnold S., Madison -1180
Jackson, Robert L., Iowa City, Iowa ---- 587
Jaeschke, Walter H. Madison ---- 307, 406, 1010
Jones, Merritt L., Wausau ---- 207
Jorris, E. H., Madison ---- 604, 782
Kiernan, Paul C., Washington, D. C. ---- 776
Killins, J. A., Green Bay ---- 859
King, Joseph M., Milwaukee --1095
Klieger, Jack A., Milwaukee --1095
Kreul, William, Racine ----1081
Kurzon, Alvin M., Milwaukee -1174
LaVake, R. T., Minneapolis --- 690
Lee, Howard J., Milwaukee -- 204
Leslie, Charles L., Milwaukee 855
Lewin, Philip, Chicago ---- 769
Longley, B. J., Madison ----1089
Lubitz, Joseph M., Wood ----1186
Luchterhand, C. K., Madison --1071
McCoy, John T., Madison ---- 672
McDonough, K. B., Madison --1099
McIntosh, R. L., Madison ---- 35
McKittrick, N. W. Milwaukee 294
McRoberts, J. W., Sheboygan - 994
Merritt, H. Houston, New York 463
Meyer, Ovid O., Madison -- 672, 988
Miale, J. B., Marshfield ---- 868
Munn, Wayne A., Janesville -- 388
Murdock, Thomas P., Meriden, Connecticut ---- 308
Musser, Marc J., Madison ---- 291
Neupert, Carl N., Madison ---- 782
Nichols, M. S., Madison ---- 218
Orth, O. S., Madison ----1002
Otis, Vincent F., Madison ----1105
Parran, Thomas, Washington, D. C. ---- 217
Pessin, S. B., Milwaukee -- 783, 876
Petersen, William J., Madison 786
Pohle, Frederick J., Madison -- 476
Pohle, H. W., Milwaukee ---- 294
Quade, R. H., Neenah ---- 583
Ries, Anthony N., Evanston, Illinois ---- 299
Ritchie, Gorton, Milwaukee -- 484
Rosenbaum, Francis F., Milwaukee ---- 989
Rosenberg, Samuel W., Milwaukee ---- 766
Ross, Willard B., Wood ----1083
Ruch, Donald M., Milwaukee -- 385
Salinger, Samuel, Chicago-382, 997
Salzman, Ferdinand A., Boston 675
Sargent, James C., Milwaukee ----1166
Schriver, L. Howard, Cincinnati ----1191
Senn, Milton J. E., New York ---- 195, 861
Shapiro, Herman H., Madison 571
Sherman, C. F., Madison ---- 296
Shuler, Virginia, Chicago ---- 700
Sims, J. L., Madison ----1103
Smedal, Magnus I., Boston --- 675
Snell, Albert M., Rochester, Minnesota ---- 199
Snodgrass, Thomas J., Janesville ---- 388
Stovall, W. D., Madison ---- ---- 38, 215, 309, 400, 487, 605, 701, 784, 879, 1163
Sudan, A. C., Kremling, Colorado ---- 607
Sullivan, James M., Milwaukee 1083
Swan, Lawrence L., New Orleans ----1092
Swanton, Milo K., Madison ---1106
Tatum, A. L., Madison 697, 780,875
Urdan, Benjamin E., Milwaukee ----1174
Vail, Derrick T., Chicago ---- 687
Veit, Henry, Milwaukee ---- 865
Weinshel, Leo R., Milwaukee--1095
Weis, Paul, Madison ---- 485
Wheeler, L. R., Milwaukee -- 401
Zintek, A. R., Madison 407, 699, 877
Zollinger, Robert M., Columbus, Ohio ---- 472

EDITORIALS

Antivivisectionists Exposed 1018
Annual Meeting ---- 788
Good Health and Healthful Living, Sudan ---- 607
Health and Peace, Chisholm --1017
Introducing the Guest Editorialist ---- 216, 310, 404, 606, 702, 1016, 1018, 1108, 1190
Medicine as a World Problem, Fishbein ----1019
Physician Shortage and Medical Care, Hirschboeck ---- 311
Practitioner and the Diplomate, The, Griffith ---- 703
President's Page ---- ---- 38, 215, 309, 400, 487, 605, 701, 784, 879, 1013, 1107, 1189
Spotlight on Research, Parran 217
Spring Clinics ---- 490
This Partnership, Jacobsen --- 405
Vivisection and Research, Elvehjem ----1109
What Now? Schriver ----1191
Your Cue, Doctor! ---- 878

SOCIETY NEWS AND ACTIVITIES

Annual Meeting, 1948
Announcement ... 493, 609
Annual Dinner ... 807, 907
Comments ... 1134
Program ... 791, 881
Reservations ... 492, 707, 795
Scientific Cinema ... 889
Scientific Exhibits ... 803, 897
Smoker ... 794, 888
Technical Exhibits ... 900
Time Table ... 704, 790, 884
Annual Reports of the Officers and Committees to the 1948 House of Delegates ... 911
Births ... 240, 628, 936, 1118
Charter Law of Medical Societies in Wisconsin ... 129
Clinics
Industrial Health ... 223
Spring ... 491
Coming Events ... 256, 642, 826, 1048
Constitution and By-Laws ... 130
Correspondence ... 330, 420, 526, 720, 824
Council Award, Recipients of ... 148
Council, Committee Appointments ... 617
Council Meetings
December 13, 1947 ... 497
January 31, 1948 ... 503
May 15 and 16, 1948 ... 1021
Councilor Districts, Map ... 128
Councilors, Photographs ... 909
Deaths ... 241, 328, 418, 522, 628, 718, 816, 936, 1034, 1118, 1240
Dues by Reference Committee on Resolutions of the House of Delegates, October 1948, Recommendations on 1949 ... 1188
Fifty Year Club, Members of the ... 137
House of Delegates—1947 ... 137
House of Delegates—1948 ... 806, 906, 1227
House of Delegates, Transactions of the 1948 Regular Session ... 1209
Joint Resolution ... 160, 940
Licentiates, Recent Wisconsin ... 315, 619, 1024
Marriages ... 240, 522, 718, 816, 936, 1034, 1118
Membership, December 1947 ... 139
New Items and Personals ... 230, 320, 412, 514 622, 712, 810, 932, 1030, 1112, 1234
Officers, Councilors, Executive Officers, State Medical Society and County Societies ... 173, 265, 357, 441, 549, 649, 741, 833, 965, 1057, 1141
Officers and Committees of State Medical Society ... 124, 908
Panel Practice, Agreement on ... 76
Past Presidents, 100 Years of ... 162
Physicians' Exchange ... 170, 264, 354, 440 546, 648, 738, 832, 962, 1056, 1138
Society Created by Territorial Legislature, 1841 ... 129
Society Proceedings:

County Societies

Ashland–Bayfield–Iron ... 224
Barron – Washburn – Sawyer–Burnett ... 228, 1110
Brown–Kewaunee–Door ... 224, 318, 409, 619, 1028, 1110, 1230
Calumet ... 224, 708
Chippewa ... 224, 409, 619, 1230
Clark ... 224
Columbia–Marquette–Adams ... 224, 409, 518, 626
Crawford ... 1230
Dane ... 234, 322, 414, 518, 716, 1030
Dodge ... 708, 1110
Douglas ... 224, 318, 409
Eau Claire–Dunn–Pepin ... 228, 318, 409, 516, 808, 1110, 1230
Fond du Lac ... 230, 409, 620, 708, 1110, 1230
Grant ... 224
Green Lake–Waushara ... 224, 516, 708
Iowa ... 708
Jefferson ... 225, 318, 409, 619, 708
Kenosha ... 225, 1110, 1230
La Crosse ... 225, 409
Manitowoc ... 225, 409, 516
Marathon ... 225, 318, 932
Marinette–Florence ... 225, 318
Milwaukee ... 236, 324
Monroe ... 410
Oneida–Vilas ... 932
Outagamie ... 226, 410, 708, 1028, 1110
Pierce–St. Croix 226, 516, 808, 1230
Polk ... 226, 1028
Portage ... 226, 410, 620
Racine ... 226, 410, 708
Richland ... 226, 318, 410, 516, 1028 1230
Rock ... 516, 708
Rusk ... 620
Sauk ... 516, 626
Shawano ... 1110
Sheboygan ... 230, 410, 516, 620
Trempealeau–Jackson – Buffalo ... 226, 410, 516, 808 1230
Vernon ... 1028
Walworth ... 228, 320, 410, 620
Washington–Ozaukee ... 226, 412, 620, 708, 808, 1028, 1110, 1232
Waukesha ... 228, 320, 410, 1232
Waupaca ... 228, 808
Winnebago ... 228, 412, 516, 620, 710, 1110, 1232
Wood ... 228, 412, 932

Councilor District Societies

Third Councilor District ... 234, 322, 414, 518, 624, 714, 814, 934, 1030, 1114, 1236
Fifth Councilor District ... 710
Sixth Councilor District ... 710
Ninth Councilor District ... 710, 932
Tenth Councilor District ... 932
Twelfth Councilor District ... 238, 326, 416, 520, 626, 716, 814, 1032, 1116, 1236

Other Societies

American Academy of General Practice, State Chapter ... 1112
American College of Chest Physicians, Wisconsin Chapter ... 1232
American Interprofessional Institute of Milwaukee ... 934
Central Wisconsin Society of Ophthalmology and Otolaryngology ... 808, 1028
Milwaukee Academy of Medicine ... 236, 324, 416, 628, 1116
Milwaukee Metropolitan Section of American College of Chest Physicians ... 326
Milwaukee Neuro – Psychiatric Society 236, 324, 416, 520, 628, 1116
Milwaukee Oto–Ophthalmic Society ... 236, 324, 416, 520, 1032
Milwaukee Surgical Society ... 1116
Section on Pediatrics ... 1112
Section on Radiology ... 622
University of Wisconsin Medical Society ... 234, 518
Wisconsin Heart Association ... 230
Wisconsin Society of Anesthesiologists ... 230
Wisconsin Surgical Club 710, 1232
Wisconsin Surgical Society ... 320, 620, 1028
Wisconsin Urological Society 518

Society Records ... 238, 326, 416, 520, 628, 716, 814, 936, 1032, 1116, 1238
Woman's Auxiliary ... 246, 332, 422, 528, 632, 722, 818, 943, 1036, 1122, 1242

BOOK REVIEWS

Advances in Military Medicine ... 1250
Allergy in Theory and Practice 634
Brief Psychotherapy ... 1248
Clinical Hematology ... 1044
Communal Sick-Care in the German Ghetto ... 338
Concise Anatomy ... 532
Congenital Malformations of the Heart ... 638
Diabetes Mellitus in General Practice ... 1250
Differential Diagnosis of Jaundice, The ... 1128
Diseases of the Chest; with Emphasis on X-Ray Diagnosis ... 164
Diseases of the Nose, Throat and Ear ... 634
Encyclopedia of Medical Sources ... 1045
Foot and Ankle, The ... 252
Hand-Book of Ocular Therapeutics ... 950
Handbook of Psychiatry ... 1042
Head, Neck and Trunk, The; Muscles and Motor Points ... 948
Headache ... 430
Heart; A Physiologic and Clinical Study of Cardio-Vascular Diseases ... 820
History of Medicine ... 250
Internal Medicine in General Practice ... 424
Manual of Clinical Therapeutics; A ... 634
Manual of Otology, Rhinology and Laryngology, A ... 823
Manual of Pharmacology; and Its Applications to Therapeutics and Toxicology, A ... 640
Mays' Manual of Diseases of the Eye ... 1128
Medical Clinics of North America; Nationwide Number ... 1046
Medical Clinics of North America, The; New York Number 1045
Medical Clinics of North America, The; New York Number 1126
Minor Surgery ... 640
Neuroanatomy ... 1044
Nursing in Modern Society ... 820
Pharmacology, Therapeutics and Prescription Writing; for Students and Practitioners ... 734
Physical Medicine in General Medicine ... 254
Physician's Handbook ... 732
Postgraduate Obstetrics ... 636
Practical Bacteriology, Hematology, and Parasitology ... 822
Practical Clinical Psychiatry 254
Practical Physiological Chemistry ... 636
Practical X-Ray Treatment ... 430
Primer of Cardiology, A ... 532
Principles and Practice of Obstetrics ... 1046
Private Enterprise or Government in Medicine ... 1126
Psychiatry for the Pediatrician ... 952
Psychobiology and Psychiatry ... 1248
Psychology of the Behavior Disorders, The ... 424
Psychopathology and Education of the Brain-Injured Child ... 730
Rehabilitation Through Better Nutrition ... 164
Rypins' Medical Licensure Examinations; Topical Summaries, Questions and Answers ... 820
Sexual Behavior in the Human Male ... 1042
Skin Manifestations of Internal Disorders (Dermadromes) ... 340
Surgical Pathology ... 950

Taking the Cure; the Patient's Approach to Tuberculosis -- 952
Textbook of Clinical Neurology, A; With an Introduction to the History of Neurology 824
Textbook of the Ear, Nose and Throat ---------- 638
Textbook of Medicine, A ----- 949
Text-Book of Pathology, A --- 948
Treatment in General Practice 822
Ulcer; the Primary Cause of Gastric and Duodenal Ulcer; Diagnosis, Medical and Surgical Treatment, Prevention 340
Unipolar Lead Electrocardiography ---------- 428
War, Politics and Insanity ---1047
Year Book of Neurology, Psychiatry, and Neurosurgery, The 1947 ----------1248

MEDICAL FORUM

	Month	Page
AAGP, Organize First State Chapter of	September	8
Aged, High Cost of Construction Revealed in Plans to Build Infirmaries	July	5
Alcoholism is no Joke—Need Help of Dr's. to Make Controls Work -------	June	5
AMA Convention, May have 30,000 Attend Annual ----------	May	1
AMCP-Blue Cross, AMA to Study Nat'l Enrollment Organization of ---------	July	3
AMCP Enlarges Staff with Budget Inc. ----------	April	1
Anesthesiologists Start Series of 1-Day Courses ----------	March	2
Anesthestists Sponsor Meetings and Speakers Bureau, State ----------	May	4
Annual Meeting Highlights ----------	October	1
Anti-Trust Suit, Oregon Service Plan in	November	5
Armed Forces, Young Doctors Obligated to Serve ----------	November	2
Army and Navy Expand Training Plans to Boost Enlistment of Medical Men	October	3
Army Service—AMA, Young Doctors Have Moral Obligation for ----------	October	7
Bach, Medicine Achieved Greatness in Free Enterprise ----------	October	8
Basic Science Exam, Reciprocity with 18 states ----------	July	4
Basic Sciences, Seven States Certify Chiropractors in ----------	July	6
Beaumont Building May be Open for Centennial ----------	March	5
Blood Program with Local Medical Societies, AMA Approves Prin. of Red Cross ----------	October	7
Blue Cross, AMA to Study National Enrollment Organization of AMCP ----	July	3
Blue Cross-Blue Shield; Bortz Sounds Warning, Hawley to Coordinate ----	February	6
Blue Cross-Blue Shield Proposal for National Insurance Co., AMA to Decide on ----------	November	1
Blue Cross Gives Financial Report ---	September	7
Blue Cross-Shield, Study Enrolling Agency for Film Catalogue Available Free for use by Doctors ----------	August	3
Blue Shield Plan, Wisconsin Physicians Service is the ----------	August	4
Board of Health-Report to State Legislative Council, Special Committee Praises ----------	October	2
British Doctors Oppose Terms of Health Act; Government Will Go Ahead Despite Opposition ----------	March	5
British Health Plan Termed a 'Tragedy'	December	2
Brookings Report Sees Too Much Politics in Federal Medicine ---	April	4
Bureaucracy, Unbounded ----------	August	2
Cancer Clinics Scheduled for July, Five	June	1
Cancer Drive in Wisconsin, Directs 1948	February	7
Cancer Drive Nets $194,265 for Wisconsin, Annual Dr's. Complaint ---------	September	3
Cancer Grant Goes to Marquette University ----------	February	
Capitol Views ----------	February	3
	March	8
	April	8
	June	2
	July	6
	September	4
	November	7
Cash Sickness Benefit System can Increase Weekly Earnings by Being Sick, Workers Under ----------	July	2
Chiropractors After Public Confidence	February	4
Chiropractors in Basic Sciences, Seven State Certify ----------	July	6
Chronic Ill, Committee Acts to Help Infirm and ----------	April	3
CIO Appoints Group to Push Health Plans ----------	May	5
Civil Defense Measure, Propose Emergency Medical Service Program for Wisconsin as ----------	May	1
Civil Defense, Seek to Integrate Industrial Medical Care and ----------	August	3
Civil Disaster Plan, House Requests State ----------	November	1
Committee Appointments, Doege Announces 1949 ----------	December	7
Compulsion, Most Doctors Would Reject	December	8
Compulsory Health "Certain" to be Studied by 81st Congress; Lawrence-	December	3
Compulsory Health Plan, Doctors Assail Ewing's ----------	December	4
Compulsory Medicine, High School Student Writes About ----------	July	3
Compulsory Medicine to Oshkosh Candlelight Group, Dr. Clark Exposes Dangers ----------	March	8
Congress are Pigeonholed, Many Health Measures in ----------	May	2
Cooperative Hospital in State, Two-Day Celebration Marks Opening of First ----------	September	8
Cooperative Hospital Plan in Duluth, Establish ----------	May	8
Co-op Health Center Files for Incorporation Papers, Superior ----------	October	7
Co-op Health Unions, Join Move for --	November	7
Co-op Plan, Announce Schedule of Benefits for Waushara Co. ---------	June	1
Co-ops Set up Regional Federation to Promote Hospital-Medical Plans ----	May	3
Co-op Hosp. in Polk Co., Start House-to-House Drive for ----------	September	1
Co-ops Start Action to Get Health Centers ----------	February	1
County Society Key Organization in Medical Care ----------	August	6
County Society Officers Meet in Chicago June 20 ----------	June	3
Crippled Children, Plan Clinics For ---	July	6
Cromwell, W. O., Bureau of Alcohol Studies ----------	July	5
Dewey Says, Compulsory Medicine No Good ----------	June	8
Disabled, Wisconsin is First with Law for Aid to ----------	November	6
Disabled Patients to Full, Self-Supporting Life, Public Law 113 Helps Physicians Restore Their ----------	February	2
Doctor's Complaint ----------	September	4
Doctor's Service, Propose Point System for ----------	December	5
Doctors to Country, States Supply Cash, Design Courses to Bring Future ----	April	2
Dorchester Flies to Rescue ----------	April	4
Doscher to Aid Public Relations ------	July	6
Draft, Amendment Removes Doctors From ----------	July	1
Draft Bill Gets Past Senate, Doctor --	June	8
Draft, Boards to Decide on Deferment of Medical-Dental Students, Up to Local ----------	December	5
Draft Figures No Index of Health, Says	February	3
Draft Physicians, May Still Try to ----	August	7
Drafted, Sargent Warns Doctors, Volunteer or be ----------	December	5
Drug, Doctors Asked to Return Dangerous ----------	August	1
Drugs, Physicians Warned of Dangerous ----------	December	6
Emergency, Council Seeks Way to Meet	May	3
Emergency Medical Service Program for Wisconsin as Civil Defense Measure, Propose ----------	May	1
Enrollment Agency, AMA OK's National; Rejects Nation-Wide Insurance Company ----------	December	1
Ewing May Head New Health Department ----------	December	4
Examiners, Board of Medical ---------	March	2
Farm Bureau Praises Wisconsin Plan; Seeks State Lab of Hygiene ---------	December	8
Farm Bureau Prescription for Better Rural Health, A. ----------	May	4
Federal Medicine, Brookings Report Sees too Much Politics in ----------	April	4
Fee Schedule, Supplement to WVMSA Red Book ----------	July	7
50-Year Club, Gold Lapel Pins Go to Members of ----------	June	2

MEDICAL FORUM—Continued

	Month	Page
50-Year Club Honors Eighteen Veteran Physicians at Milwaukee, Second Meeting of	October	4
Form 100, Doran Reminds, Date of First Treatment Must be Reported on	June	2
Form 200 Can be Used to Get more Treatment than First Authorized	June	6
4-H Club Members Attend Health Camp, Medical Society Scholarships	October	5
Gavin Head Health Board, Thompson and	September	1
Goin, Health of Nation Not as Bad as Claimed by Socializers, Dr.	July	5
Group Practice, Send Questionnaire for Study of	April	1
Gundersen Elected to AMA Board of Trustees	July	1
Handicapped Persons, Crownhart on Governor's Committee to Employ	October	4
Hawley as VA Medical Director, Magnuson Replaces	February	1
Hawley to Coordinate Blue Cross–Blue Shield; Bortz Sounds Warning	February	6
Health a "Political Maneuver," Call Federal	December	4
Health and Accident Coverage up 18% in 1947, Premium Income from	May	5
Health Assembly, Complete Plans for U. S.	April	6
Health, Legislature Asks Society's Help to Study State Board of	April	6
Health Measures in Congress are Pigeonholed, Many	May	2
Health, Name Special Medical Society Committee to Aid Legislative Study of Board of	May	6
Health Plans, CIO Appoints Group to Push	May	5
Heiser, Sander to Assist with Industrial Clinics	April	2
Hearing Program, Doctors Cooperate in Wisconsin	September	6
Hennessy is New Secretary of NEMS	October	4
Hippocratic Oath, Plan Revision of	October	6
Hospital-Medical Plans, Co-ops Set Up Regional Federation to Promote	May	3
Hospital Plan, New Priority List for State	June	1
Hospital Projects Named for Federal Aid, Seven	September	5
Hospitals, Davis Opposes Legion Plan on Vet	April	5
Hospitals, Figures Show Economic Outlook for	April	4
Hospitals, Request Federal Funds for Seven New	March	4
Hospitals Last Year, Report Shows 18 Million in	September	3
House of Delegates Acts on Merger of Milwaukee, State Prepaid Plans	October	1
Howard Joins AMA Staff, Dr. Ernest	June	7
Industrial Clinics, Heiser, Sander to Assist with	April	2
Industrial Health, A Guide for Medical and Nursing Personnel	March	7
Industrial Health Clinics Attract 565 Delegates	June	4
Industrial Medicine, AMA Sets up Residency in	April	5
Industrial Health Men Pay Tribute to James	August	6
Infant and Maternal Deaths, Seek Data on	March	4
Infirm and Chronic Ill, Committee Acts to Help	April	3
Infirmary Bill, Revise County	November	5
Infirmaries for Aged, High Cost of Construction Revealed in Plans to Build	July	5
Insurance, AMA Officers Fly to Japan to Study Sickness	August	6
Insurance Company, Rejects Nation-Wide; AMA OK's National Enrollment Agency	December	1
Insurance? State Health	December	2
James, Industrial Health Men Pay Tribute to	August	6
Japan to Study Sickness Insurance, AMA Officers Fly to	August	6
Lawyers Seek Improvement of Expert, Testimony, Doctors and	March	1
Laymen, for Contributions to Medical Progress, Will Honor	August	1
Legislative Council Finds Facts, Studies State's Problems Between Sessions, Wisconsin	April	8
Legislative Council, Special Comm. Praises Board of Health-Report to	October	2
Linicome and Rasmussen Join U. W. Medical staff	March	3
M. D.'s in House, "Not too Much Expected" from 7	December	6
Magnuson Explains How VA Fees are Set for Home-Town Physicians	December	7
Magnuson Replaces Hawley as VA Medical Director	February	1
March of Medicine Ends Third Year as Radio Program	April	7
Medical Advisors to Serve on State Selective Service System, Begin Appointment of	November	2
Medical Examiners License 259 in '47	February	7
Medical Loans, Illinois SMS Picks Three Farm Students for	October	8
Medical Practice Act, Uphold New Jersey	November	7
Medical Progress, Will Honor Laymen for Contributions to	August	1
Medical Testimony, Seek to Insure Proper Expert	November	5
Medicine, Charges Plot for World-Wide Government Control of	December	4
Medicine, Shawano Newspaper Favors Continuation of Free Enterprise System in American	September	4
Mental and Chronic Cases Report High Rate of Hospital Care of	August	4
Mental Hospitals Far Below Standard, State's	December	1
Mental Hospitals, Society Studies	November	3
Merger of Milwaukee, State Prepaid Plans, House of Delegates Acts on	October	1
Michigan Annual Session, State Doctors Asked to	August	8
Middleton Renamed to Advisory Post with VA	April	4
Midwest Regional Conference, Can't Fool Public, Doctors Warned at the	February	2
Military Medical Training, Expand	May	6
Money, Survey Tells Answer Who Earns the	October	6
Narcotic Agent Issues Warning	August	5
National Health Assembly Called at Truman's Request	March	5
National Health Assembly, Form Permanent Steering Committee on	August	8
National Health Assembly, Wisconsin Doctors at	May	1
National Medicine, Physicians to be Assessed $25 for Fund to Fight	December	1
Navy Opens Ranks to Doctors, Regular	February	5
Night Calls, County Societies Asked to Assure	September	1
Night Calls, County Medical Societies Asked to Solve Problem of	March	1
Nurses Hold Institute in Milwaukee, Industrial	February	5
Nurses Meeting until February 4–5 Postponed	November	4
Nurses Now Than Ever Before, More	February	7
Nursing Institute, Doctors Invited to	October	5
OB–Gyn Congress to be International Meeting, 4th	February	4
Oregon Service Plan in Anti-Trust Suit	November	5
Parran to Leave April 6, Scheele Surgeon General	March	1
Parent-Teachers Announce Health Program; Suggest Local Action Comm.	October	3
Physicians Averaged $9,884 Net Income during 1947, Private	October	7
Physicians Educated in Foreign Schools, Board Gives Ruling on Licensing of	November	3
Practical Nurses Offered at Kenosha School, Nine Month Courses for	November	4
Practical Nurses Trained at Milwaukee Vocational	October	6
Preceptors at Scientific Meet, 32	December	3
Prepayment Medical Care Plans, News of	March July September	2 2 7
Press, Comments from the Wisconsin	February March April August October	6 3 8 2 5

MEDICAL FORUM—Continued

	Month	Page
Pressly is Family Doctor of 1949	December	3
Public Health Council, Establish Wisconsin	August	1
Public Health Workers; Earn-While-You-Learn-Plan for Physicians, Raise Salaries for	May	8
Public Law 113 Helps Physicians Restore Their Disabled Patients to Full, Self-Supporting Life	February	2
Public Relations, Colorado Sets Pace for Medical	February	8
Public Relations Convo in St. Louis, Nov. 27	August	8
Public Relations in Practice	August	8
	September	8
	October	8
	November	8
	December	8
Public Relations Is Service and Understanding, Doctors Are Told at Secretaries' Conferences	June	7
Quacks out of Business, San Diego Puts Mental	September	2
Radio Program, March of Medicine Ends Third Year as	April	7
Radiologists Fear Attack from Within	September	7
Rasmussen Join U. W. Medical Staff, Linicome and	March	3
Reciprocity with 18 States on Basic Science Exam	July	4
Rural Practice at Meeting, Interns and Residents Learn about	August	5
St. Louis Session Invited GPs to	November	8
Sander to Assist with Industrial Clinics, Heiser	April	2
Sargent and Bortz Are Medical Advisors to Security Resources Board	August	5
Savings Barrel, Consumers Hit Bottom of Their	August	5
Scheele Surgeon General; Parran to Leave April 6	March	1
School Health Bill Would Give 'Free' Care to More Than 30,000,000 Children	April	3
Seal of Acceptance, Wisconsin Prepaid Plans Get	February	4
Secretaries' Conferences	May	7
Secretaries' Meetings to Be Held in May and June	April	6
Security Resources Board, Sargent and Bortz are Medical Advisors to	August	5
Selective Service System, Begin Appointment of Medical Advisors to Serve on State	November	2
Social Medicine in 80th Congress, No Chance for	July	3
Social Security Problems for Chamber of Commerce, Name Committee to Study	March	2
Social Medicine?" Writer Asks, "Is Vet Program Nudging Us Into	September	5
Socialized Then Come Editors?", "After Doctors Are	May	8
"Spanish Swindle", Doctors Are Victims of	May	6
Stassen, Keep Medicine Free	June	8
State Health Insurance?	December	2
State Medical Society, Purchase Home for	April	1
Streptomycin Requests, VA no Longer Honors	February	1
Surgeon's Education Costs over $30,000	November	8
Syphilis Records Available to Doctors,	June	5
Taussig-Blalock Get $5,000 Passano Award	August	3
Testimony, Doctors and Lawyers Seek Improvement of Expert	March	1
Thompson and Gavin Head Health Board	September	1
Truitt is President-Elect of Medical Society	October	1
Trustees, Gundersen Elected to AMA Board of	July	1
Tuberculosis Fellowships, T-B Association Sets up	February	6
Undulant Fever More Serious than Polio	December	5
VA Clarifies Procedure Used When Veteran Applies for Treatment	March	6
VA Fees are Set for Home-Town Physicians, Magnuson Explains How	December	7
VA Praises Service of State Physicians	February	8
VA Programs, Seek Uniformity in	July	1
VA Sets Up Standards to Select Specialists	August	6
VA Starts Residency Classes, Tomah	August	7
VA, Vogl New Chief Medical Officer at Regional	September	7
Veterans Agency Advises to Treatment of Veterans	March	8
Veterans Propose National Prepaid Plan for All	November	6
Veterans Training for Medicine, One of Every 25	May	2
Vets Need Claim to Get Treatment	May	1
Vet Program Nudging us into Social Medicine?" Writer Asks, "Is	September	5
Vivisection Needed to Save Lives, Bring Medical Advances, Doctor Says	June	6
Vocational and Adult Education, Name Medical Advisors to Board of	September	3
Vogl New Chief Medical Officer at Regional VA	September	7
Warren Urges Compulsory Medicine for Califorinia, Gov.	June	8
Wis. Physicians Service and Blue Cross Report on Progress	February	4
Wis. Physicians Service Gains from Successful Blue Cross Drives	May	5
Wis. Physicians Service is the Blue Shield Plan	August	4
Wisconsin Physicians' Service, Nearly 100,000 Persons Covered by	December	6
Wis. Physicians Service Pays $90,000 Benefits in first 13 Months	March	6
Wisconsin Plan Adds 375 Doctors to List of Participating Physicians and Surgeons	April	5
Wisconsin Plan by May 31; Competition to Set Premium Rate Structure, New Policies for	February	5
Wisconsin Plan Covers 3 500 Employees of Madison Packing Plant, "New"	September	2
Wisconsin Plan, Doctors to Bill According to New	June	3
Wisconsin Plan, Farm Bureau Asks 75% Enrollment in	November	3
Wisconsin Plan Policies Are Effective on May 31, New	May	4
Wisconsin Plan Reports Progress	August	7
Wisconsin Plan; Seeks State Lab of Hygiene, Farm Bureau Praises	December	8
Wisconsin Public Health Council Establish	August	1
WPS, Benefits Director Asks, Be Familiar With	August	4
WPS–Blue Shield Plan: Weber, Payment of Doctors Speeded up in	September	3
WPS Pays Quarter Million in Benefits in 13 Months	July	2
Wood Produce Play at Medical Meeting, Residents at	October	4
Woolsey Named to New Professorship at U.W.	October	2
Workmen's Compensation Panels	March	7
WVMSA Forms, Don't Wait Until Last Day to Send in	June	7
WVMSA Red Book Fee Schedule, Supplement to	July	7

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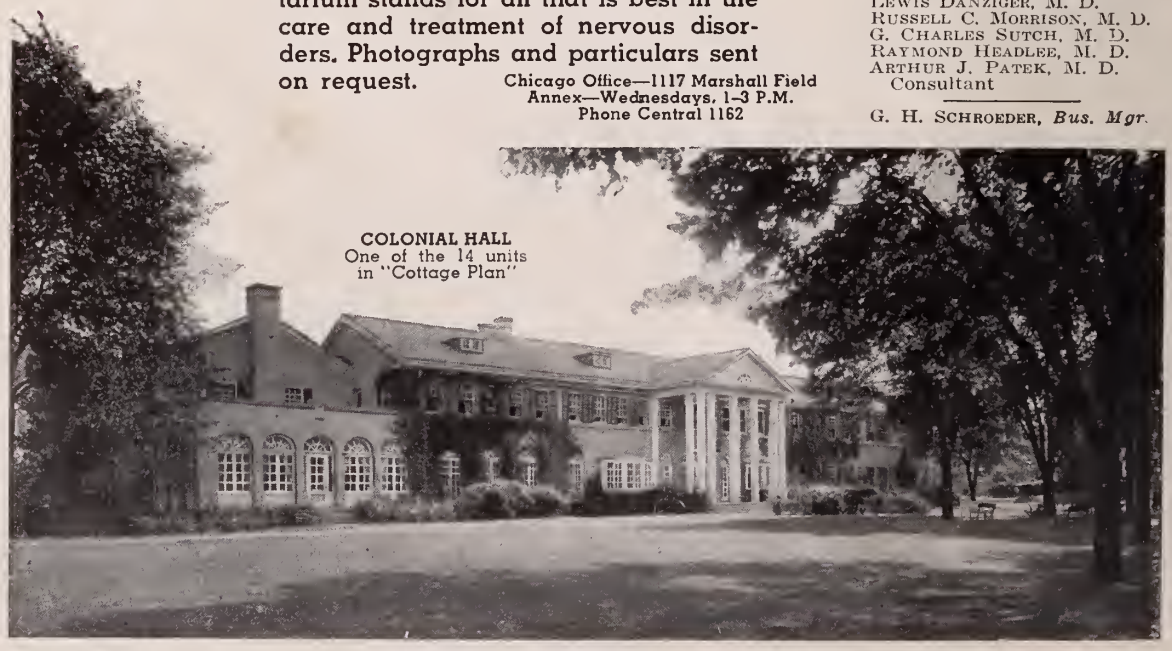

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